Tuesday, 8 July 2025

(10.22 am)

MS TROUP: Good morning.

THE CHAIR: Ms Troup, over to you.

MS TROUP: Thank you.

KARON PIMM (affirmed)

Questioned by MS TROUP

MS TROUP: Good morning.

A. Morning.

Q. Could you first please state your name for the record?

A. Yes, Karon Christine Pimm.

Q. Karon, I am going to ask you first of all to just either move the microphone slightly towards you or to move yourself a little bit closer to it --

A. Sorry.

Q. -- because I can hear that you are a little bit quiet?

A. Is that better?

Q. I think it is, I think it is. Thank you.

A. Okay.

Q. Karon, you are the mother of Terrence Joseph Pimm, who died on 26 August 2016 when he was 30 years old, yes?

A. Yes.

Q. To check, you would like me to refer to your son as TJ throughout your evidence --

A. Yes, please.

Q. -- and to you as Karon?
A. Yes.
Q. By way of background, the Inquiry sent to you and to your representatives a number of months ago a request for evidence under Rule 9 and you provided in response a witness statement that I think you have in front of you now?
A. Yes.
Q. You have a copy of it there?
A. Yes.
Q. It is 39 pages long and, if you turn to the last page of it, please, to page 39, it is dated 4 June of this year and that is the page where you have also signed, yes?
A. Yes.
Q. And made a statement of truth?
A. Yes.
Q. Are you happy sitting there now that this witness statement is accurate?
A. Yes.
Q. So, Karon, you know that that witness statement therefore stands as your evidence?
A. (Witness nodded)
Q. All of it will be taken into account by the Chair and by this Inquiry. What you and I are going to do today is not go through it line by line but take you through some

of the key events and some of the key concerns that you have raised in relation to failings in the care and treatment of TJ?

A. Okay.

Q. You also, I want to acknowledge, gave commemorative evidence about TJ in September 2024 when we were back in Chelmsford --

A. Yes.

Q. -- and you gave a very full account about TJ as a person and his life and some of the events leading to his death?

A. Yes.

Q. For that reason, we won't go over those again today --

A. No.

Q. -- because the purpose of this is to talk about care and treatment.

A. Yes.

Q. So one of the first things you tell us is that you were not involved in some of the early stages of TJ becoming unwell; is that right?

A. Yes.

Q. What has happened is that you have now had access to some of his medical records, including his GP records --

A. Yes.

Q. -- which have given you a picture of how TJ was across

the period from sort of 2010, all the way through to August 2016?

A. That's correct, yes.

Q. But is it right that, at the time, TJ didn't really share any of the details of how he was doing or what was happening for him?

A. No, he wasn't. He wasn't telling us, no.

Q. He wasn't what, I am so sorry?

A. Sorry, wasn't going through us. I think we knew once he had been to the doctors and that was it.

Q. Yes.

A. But, yes, no, I didn't know when I read some of the stuff.

Q. You didn't know?

A. I didn't know he had even registered with the GP when he moved in with a girlfriend.

Q. Yes.

A. Yes.

Q. One of the things that I think is really important to note from your witness statement is that you tell us a number of times that one of the parts of TJ's character was that he often didn't share anything that he thought might upset you --

A. Yes, yes.

Q. -- or your husband --

A. Yes.
Q. -- or your daughters and you say also that he was a person who was quite life and soul of the party?
A. Yes.
Q. I think you say in one part that he had the gift of the gab?
A. Yes, definitely.
Q. What that also meant was that he was very good -- the way you put it in your witness statement is that he was very good at masking the true picture when he was really struggling?
A. Yes, yes. He was a bit of a Billy Liar, as well. He used to tell lies and, you know, he didn't -- he didn't mean nothing bad by it, but --
Q. No. Well, the impression I get, and you must tell me if this is wrong, is that, in fact, he was trying to protect you --
A. Yes, yes.
Q. -- rather than -- those things that were untrue, where he would say he was fine or not tell you or your husband how bad he was feeling --
A. Yes.
Q. -- were intended to protect you. I think we will come on to it but, actually, in your mind it's very clear that that became quite dangerous because he was so good

at masking what was actually happening for him --

A. Yes.

Q. -- that he did that extremely well in front of clinicians and mental health professionals?

A. Yes, definitely.

Q. As we will come on to see, I think that is one of the reasons why, when you became aware that TJ was seriously unwell and needed psychiatric intervention, you made desperate efforts to be allowed to explain to clinicians --

A. (Witness nodded)

Q. -- that he was very good at masking in this way. Would it be fair for me to say that what you were trying to get across first and foremost was that what TJ said should not be taken at face value?

A. Yes, I said he'd hoodwink them and he did. When he first came out from the first time at The Lakes, he met me because I was there and he said, "No, I told you, there's nothing wrong with me".

Q. Did he --

A. "It's just drink".

Q. All right, we'll come to that. So the two really key events that I would like to talk through with you first, we know from your witness statement -- and I don't think we need to go through it -- that, having looked back at

the GP records, in fact TJ had been struggling with his mental health from around about 2010 and there had been a series of referrals, either to local services --

A. Yes.

Q. -- like Rethink, or to drug and alcohol services, principally alcohol services --

A. Yes, yes.

Q. -- because during the period from about 2012 onwards, he did again to struggle with alcohol use?

A. Mmm.

Q. Yes?

A. Yes.

Q. Karon, you must tell me if this is wrong, but I think it's your view that his struggles with alcohol came after he began to struggle with his mental health; is that right?

A. Yes, he liked a drink, social drink, whatever.

Q. Yes.

A. But then it just got out of hand and he didn't end up coming home sometimes, especially when he was working in London. It was a lot worse there.

Q. So that was in 2012?

THE CHAIR: You talked about him masking things but you suggest he was quite open about his drinking problem; is that right?

A. Well, we knew.
THE CHAIR: Obviously, you could see it.
A. You can tell, can't you?
THE CHAIR: Did he acknowledge it though, that it was an issue?
A. I think he did in the end. But, in the end, when he knew he couldn't drink no more, he just laid in bed, he was so depressed and he grew a big beard and silly things like that. I don't suppose he thought it was an issue, I don't think he did think the drink was an issue, to tell the truth, because he was a young boy working in London, or wherever he was working at the time, and that's what they do.
THE CHAIR: Thank you.
A. Yes.
MS TROUP: You told us in your witness statement about a period when he took a job in London, where you and your husband feel that he did become increasingly reliant on alcohol --
A. Yes.
Q. -- and the workplace that he was in at the time was one there was quite a heavy culture of drinking and drugs --
A. Mmm.
Q. -- and that that wasn't good for him?
A. No.

Q. Thereafter, he came back to live with you in about March 2012, after he had quit his job in London?
A. Yes, yes, yes.
Q. What you say then is that, from that period onwards, he had begun to have a low mood that sort of stayed, a depressed mood that didn't seem to lift?
A. Exactly, yes.
Q. Karon, what you have set out really helpfully in the records is the number of visits he made to a GP, either to ask to be restarted on antidepressants or to ask for help?
A. Yes.
Q. One of the things that you say, and you must tell me if I have it wrong, is that, looking back on those records and in the lead up to TJ presenting as acutely in crisis in August 2016, you are surprised that the GP was not more proactive --
A. Yes.
Q. -- in following up because --
A. Yes.
Q. You go ahead.
A. Sorry, I was just going to say because, yes, from 2010, he had been at our doctors, I think, then he registered at another one?
Q. Yes.

A. But the doctors where we lived, first of all, never done anything or didn't follow anything up.
Q. Yes.
A. I know it's up to you to take responsibility for what you are trying to find help for but, if you don't know you are ill --
Q. Yes.
A. -- then you can't, so that's up to them to step in --
Q. And help.
A. -- and follow up, like you would follow up someone who presented with a lump on their whatever.
Q. Yes. Yes, I understand.
A. Yes.
Q. If we come to the beginning of August 2016 --
A. Yes.
Q. -- you told us in your commemorative evidence, and you have set it out again in this witness statement, that there came a day on 8 August 2016 when one of your daughters received a call from TJ's girlfriend at the time to say that he was very drunk and at a railway station threatening suicide?
A. Yes.
Q. Railway staff brought TJ back to your daughter's home.
A. Mmm.
Q. From there, British Transport Police became involved,

paramedics attended. As I understand it, on that day, you spoke to police who called to tell you what was happening?

A. Yes, I was on my way from Dovercourt to Romford.

Q. Yes, and the way that that ended up is that police detained TJ under Section 136, in order to carry out a 72-hour detention --

A. Section.

Q. -- for assessment?

A. Yes.

Q. My understanding from your witness statement is that both you and your husband were incredibly relieved --

A. Yes, yes.

Q. -- that that happened?

A. We all were, yes, yes.

Q. Tell me why you were so relieved at that point that he had been taken in?

A. He wasn't eating, he wasn't -- he was just going in himself. He looked terrible, he was a nice looking kid but, yes, I said he got a big beard and Terry said to him "Shave that off, that's not you, you don't wear beards like that". He had no interest, in the end he was just laying -- laying around doing nothing, really.

Q. Yes.

A. And, yes, we knew he needed help, and he knew. I think

he knew he needed some help, that's why he had been to the doctors.

Q. Yes.

A. But, I don't know, they didn't pick up on the right things, I suppose.

Q. Who didn't pick up?

A. It's easy for me -- the doctors.

Q. Yes, I see.

A. But then, you know, if you don't tell truth, how are they going to know --

Q. Yes.

A. -- and I don't know what he said to the doctors. But I could see different things. Me and TJ were like that.

Q. You were very close?

A. Me and him were, yes, yes.

Q. Yes. Karon, I understand that first on that date -- so we are on 8 August.

A. 8th.

Q. Yes, TJ was taken to Goodmayes Hospital?

A. Yes.

Q. You understood that he was going to be assessed there?

A. Yes.

Q. But, actually, for reasons that are still not clear to you, an immediate transfer was made to the Harbour Suite at The Lakes?

A. Yes.
Q. Is it right that you -- so no assessment took place at Goodmayes at all?
A. No, there is no paperwork that he even attended there. I think he must have got there about -- I don't know, I'd be guessing, he must have got there about perhaps 4.00 --
Q. 4.00 pm?
A. -- or 3.00 --
Q. Yes, okay.
A. -- at that time, and I'm pretty sure they transferred him at midnight without an assessment.
Q. Yes. So he was transferred to The Lakes and because --
A. Because he was out-of-area, not because he needed help --
Q. Yes.
A. -- somewhere else, they could have done their assessment.
Q. Because Goodmayes was out-of-area?
A. They said he is out-of-area, so I think -- I have got the understanding, I think they put him in a taxi. I don't know if anyone accompanied him, I have not seen that information.
Q. I see.
A. I still do not know to this day but that was my

impression that I remember, and that was at midnight.
Q. Yes. It's my understanding --
A. This is after a kid that's gone to a railway station to kill himself.
Q. Yes.
A. Sorry.
Q. You take your time?
A. I'm trying not to cry.
Q. There is nothing to apologise for, Karon. Like I said to you before, if you need to stop or you need us to have a break, you tell me, you interrupt me, you let me know.
A. Sorry, can I just go --
THE CHAIR: Of course.
MS TROUP: Of course. Of course.
A. Sorry. (Pause)
MS TROUP: Chair, I'm being advised we might now ask you to rise for 10 minutes for a pause.
(10.37 am)
(A short break)
(10.52 am)
MS TROUP: Chair, thank you.
THE CHAIR: Thank you.
MS TROUP: Karon, as long you're ready, we will go on.
A. Yes.

Q. You feel confident to tell me when you need another break?
A. Yes, okay, yes.
Q. I am going to bring you back to just after midnight on 9 August and I think it was around about that time that you learned that TJ had been transferred to The Lakes. My understanding was that, from that time onwards, you repeatedly phoned The Lakes --
A. Mmm.
Q. -- and you did that with the specific purpose of asking that whoever was going to assess TJ --
A. Yes.
Q. -- be made aware that you wanted to speak to them --
A. Yes, and I was in the building working.
Q. Now, yes. You are a nurse --
A. Yes.
Q. -- and, at the time, you were working in the next door building?
A. Yes.
Q. You were due to be at work on the following day?
A. Yes.
Q. Actually, it is the same day --
A. Yes.
Q. -- because we are at midnight on the 9th.
A. Yes.

Q. Sorry.
A. That's all right.
Q. So you started to phone after midnight and you repeatedly asked to speak to whichever clinician was going to be assessing TJ?
A. Yes, mmm.
Q. You also explained what we have discussed --
A. Yes.
Q. -- that TJ would minimise his own symptoms --
A. Yes.
Q. -- and his own feelings and was likely to say, "I am all right"?
A. Yes, yes.
Q. As I understand it, before TJ even got to Goodmayes and then to The Lakes, your daughter had also told both police and paramedics that they must warn whichever clinicians TJ was being handed over to --
A. Yes.
Q. -- that he would do that?
A. Mmm, yes, she knew as well, yes.
Q. Is this right: no one ever phoned you back from The Lakes?
A. Yes, completely, never. We must have phoned about 10, 12 times.
Q. You phoned 10 or 12 times?

A. Yes, it was Harbour Suite, I remember it.
Q. The Harbour Suite. You remember the calls?
A. There was a lot of calls.
Q. Of course. At one point, I understand that the member of staff you spoke to said something like "He's 30 years old"?
A. Yes, that was the other thing. Yes. Yes.
Q. Now, you must tell me if I am wrong but, from what you have told us and from your witness statement, I think the point you are making is that his age was irrelevant --
A. Yes.
Q. -- because what you were trying to get across was that you desperately wanted to input some information for whoever was going to be --
A. Yes.
Q. -- carrying out that assessment?
A. Yes.
Q. The next morning, you went to work in the next door building --
A. Yes.
Q. -- to the Harbour Suite at The Lakes and you called again?
A. Mm-hm, mm-hm.
Q. You were told that he was still waiting for

an assessment?

A. Yes.

Q. You kept calling, he was still waiting for an assessment?

A. Mmm.

Q. The next call that you got was from TJ to say, "I have been assessed" --

A. Yes, yes.

Q. -- "there's nothing wrong with me".

A. Yes, yes. And he was just waiting for me there, for when I finished?

Q. Yes, so he waited for you to finish and you went and collected him?

A. Yes, because I think I was on a half day, so I finished between 12 and half 1 -- half 12, sorry.

Q. Yes, and he told you at the time that he had been seen by a number of mental health professionals?

A. Yes, but I think -- I don't think they was -- I remember something, they weren't the right ones what he said were in the room. There was supposed to be a psychiatrist --

Q. Yes.

A. -- but she was a locum --

Q. Right.

A. -- and a psychiatric nurse --

Q. Yes.

A. -- and a social worker but I don't believe -- I have not seen any evidence but I don't think they were the people that were in that room at the time.
Q. No, but, in any event, you didn't know it was taking place and you weren't asked to attend?
A. No, no, no.
Q. Can I take it that you would have gone?
A. Oh, God, yes. It is literally 200 yards from me, in a different building, yes.
Q. Yes.
A. Yes.
Q. Looking back on it, you have been able to see the clinical records that were made during that assessment at the Harbour Suite at The Lakes. If you want to follow it -- you don't need to -- but if you want to follow --
A. What page are we on?
Q. I am on page 11?
A. I have read them before but I haven't looked --
Q. It is only if you want to follow, you don't need to.
A. Yes, yes.
Q. I am on page 11 and I am looking at paragraph 50 --
A. 50.
Q. -- in the middle of the page.
A. Yes.

Q. So what the records tell you is that TJ was assessed by a consultant psychiatrist --
A. Mmm.
Q. -- a nurse, who was an approved mental health professional --
A. Mmm.
Q. -- and TJ was recorded -- I will read it, if that's all right --
A. Yes, yes.
Q. -- so everyone is clear, as "presenting as forthcoming and insightful, who made plain that he is not mentally ill" and TJ's presenting problems were assessed as "entirely alcohol related". Can I put it in this way, the purpose of all those calls you had made to The Lakes was to avoid exactly that outcome?
A. Exactly, yes, exactly.
Q. Yes. No plans for follow up of any kind were made?
A. No, but I thought, as I said to you about a social worker, there was mention of a social worker and they are supposed to follow up and do things.
Q. I see.
A. And he told me that they had made an appointment for a community psychiatric nurse to visit.
Q. I see, so a community team to come and visit?
A. Yes, yes.

Q. Did you ever hear anything about that again?
A. No. But that is not a thing he could make up because he wouldn't know about community teams working in the community, mental health teams? He wouldn't know. So it must have been said to him that was going to happen.
Q. So it was TJ who told you that?
A. He told me that, yes, yes.
Q. I understand.
THE CHAIR: Can I just go back to the time you telephoned --
MS TROUP: Of course.
THE CHAIR: -- to say you wanted to speak to the clinicians?
A. Yes.
THE CHAIR: Did you make it plain to them that you were working next door and could come and talk to them; do you remember?
A. I don't think there was any messages passed on. I think they were just appeasing me.
THE CHAIR: Did you say that though to whoever it was you spoke to?
A. They know I was there, yes, I said "I am working there" --
THE CHAIR: You said that?
A. -- because he was transferred like 12.00 and I was on shift that morning, so he was still there.
THE CHAIR: Yes.

A. Yes.
THE CHAIR: Thank you.
A. Yes, they knew 100 per cent, and it was the same person answering all the time because they don't have so many staff, I don't think, for night.
THE CHAIR: Thank you.
A. That's all right.
MS TROUP: Thank you. One of the things you had said, as I understand it, on those calls and that you were very clear about in your own mind is that what TJ would say when he was assessed --
A. Yes.
Q. -- was that the problems were to do with his drinking and he would reduce his alcohol intake?
A. Mmm.
Q. Then there we have that exactly reflected in the records, you were quite right --
A. Yes.
Q. -- that's what he did?
A. Yes.
Q. There may have been some discussion about a referral to a community team. As far as you are aware, did any such home visit ever take place?
A. No, no.
Q. No. What I pick up from your witness statement, Karon,

is that you feel very strongly and, again, you must tell me if I have this wrong, that if you had been able to give some information to the assessing clinicians about the background and the history of TJ's expressions of suicidal intent and how low he had been, and if you had been able to explain how he would present, it is your feeling that he wouldn't have been discharged at that time?

A. I wouldn't have let him come out the building, so -- but I couldn't get in the building, so I never had the choice.

Q. Yes.

A. Simple as that, yes. I couldn't believe it when he come out and met me after work, I just still couldn't get over it.

Q. Yes.

A. I knew there was something wrong but, yes, he spoke his way out of it, again.

Q. Forgive me.

A. That's all right.

Q. When he came out and you took him home, or he wanted to go to his girlfriend's, I think, but my question is, as far as you can remember, were you given any kind of information about how to keep TJ safe?

A. No.

Q. Where to go next for help?
A. No.
Q. What to do?
A. No. I think he might have gone to one Alcoholics Anonymous meeting but I never knew that, I think I read it somewhere.
Q. Yes.
A. But I am not sure if that's true.
Q. I understand.
A. I don't know if it's something he said.
Q. But on the day there was no engagement at all with you from staff at The Lakes or anyone --
A. No.
Q. -- who had been involved in that assessment --
A. No.
Q. -- about what should take place next or any kind of plan?
A. No, I never see them again until the coroners -- the people that were involved up there --
Q. You didn't see those people again --
A. -- at the inquest.
Q. -- until inquest?
A. No, I'd never met them before anyway but that was when I saw them.
Q. I understand, I understand. There doesn't seem to have

been then -- and it may be to do with the way in which TJ presented when he was assessed, but that's exactly what you were trying to warn of, and one of the things you tell us in your witness statement was that what was so shocking and upsetting to you is that there doesn't appear to have been any kind of exploration of what might underlie the way in which he had presented?

A. (Witness nodded)

Q. He had been at a train station talking about suicide just that day --

A. Yes.

Q. -- and, to you, I think, is this right, it feels as though that was just sort of dismissed?

A. Yes, no, how can they let him --

Q. Yes.

A. Less than 24 hours, roughly, they have let him out --

Q. Yes.

A. -- from being picked up at Romford, the British Transport Police, calling the paramedics, taking him to Goodmayes, and letting him round about 12.00 the next day.

Q. One of the things you have learned is that the paperwork that was completed for that assessment at The Lakes included a section for information from the nearest relative --

A. Yes.
Q. -- which was --
A. Blank.
Q. -- of course, left blank.
A. Mmm.
Q. Now, Karon --
A. So why is that there?
Q. Yes, go ahead.
A. And that's not a juvenile place, that's adults, not juveniles.
Q. Adults, yes.
A. So why have they got the same paperwork asking for family or friends' input?
Q. Yes.
A. So it must be something they should be doing. Well, they have got to do it.
Q. Did you say it must be something they should be doing?
A. They should be, shouldn't they, yes, yes, especially if you are ringing and asking to speak and say, you know, I need to speak to the doctor before he has his assessment, like I did, and nothing, nothing.
Q. Yes, in fact, I think that's one of the points you make, which is that, even if, in these particular circumstances, even if you had not been as proactive as you were and made those desperate attempts to speak to

someone, that section of the form is there for a reason --

A. Yes.

Q. -- and the views of a nearest relative, if available, should at least be sought?

A. Before they let him out, yes.

Q. Yes, one of the other things I want to take you to is that, at a much later stage, there was a civil claim against the Trust, in respect of the circumstances of TJ's death --

A. Mmm.

Q. -- and that involved a lot of detail around this assessment at The Lakes --

A. Mmm.

Q. -- on the 9th and, Karon, if you want to follow it, I am looking now at page 31 of your witness statement and paragraph 142.

A. Yes.

Q. You don't need to but just so that you know where we are up to. In summary, the experts who were asked to analyse the way in which that assessment had been carried out --

A. Yes.

Q. -- concluded that it had been inadequate on a number of fronts?

A. Yes.
Q. What one of those experts said was that there was no evidence to indicate that the assessing team had sought to establish anything about TJ's background or about the triggers to his acute presentation, and that the focus solely on his problems with alcohol led to an assessment that wasn't realistic --
A. No.
Q. -- essentially?
A. Not at all, no.
Q. If a better evaluation had taken place at the time, it was those experts' views that follow up would have been offered at the very least, and some sort of psychiatric care plan?
A. Yes, but, but all I -- I think is that, still, he should have been sectioned, there and then --
Q. Yes.
A. -- from the day before.
Q. Yes.
A. You don't let someone out who tried to jump in front of a train 24 hours later, there's got to be something wrong and he weren't drunk. He'd a drink but in the time he got to them, 12 -- sorry, 24 hours later --
Q. Yes.
A. -- he was sober.

Q. He was sober, yes.

Those experts, or at least one of them, was also very critical of the failure to engage with you about that assessment?

A. Yes. Sorry.

Q. That's all right. When TJ came home to you, as far as I understand it, in the period then before we see him presenting for psychiatric help again, which comes on 25 August, he remained very low in mood --

A. Mmm.

Q. -- to the extent that you and your husband were desperate to seek help for him?

A. Yes.

Q. There had been an incident previous to this, where TJ had been charged with an assault and this was in relation to an altercation that took place with a girlfriend of his. You were actually a witness to that incident?

A. I was, I was picking him up and picking his stuff up.

Q. Yes.

A. And it sounds wrong that he had a warrant out for his arrest, yes, but for assault, but the assault was on the phone.

Q. Yes.

A. He slammed -- she'd got a phone from work for him that

day before, actually --

Q. Yes.

A. -- and she asked for it back and he says, "Is that all you want?" and he threw it on the floor.

Q. Yes.

A. But I said to the police that there was a Spar. We was outside, parked upfront, like some little shops, and there was a camera. I said, "Why didn't you look at that?"

Q. Yes.

A. But, to me, I still don't know what he was charged with but it's assault but it sounded wrong that it was put in the papers and everything. No one ever said it was assault of a phone. He never touched her, I was there.

Q. I understand that, and that was --

A. He never touched any person, no, he weren't that way.

Q. No, no. I understand. So one of the things that had happened as a result of those charges, whatever they were, is that he had pleaded guilty and been sentenced to a community order and also there were restrictions on his contact with this ex-girlfriend?

A. Yes, yes.

Q. But, for our purposes, I think what's important is that he was, in fact, due to appear at the Magistrates' Court on 23 August --

A. Mm-hm.
Q. -- and didn't attend --
A. No.
Q. -- court?
A. No.
Q. So you and your husband tried to help him on that day. It was your view that he was scared about what was going to happen when he went to court --
A. Yes, yes. Yes.
Q. -- and he wasn't well?
A. And he wasn't well, that's the main thing, and I'll bet he was thinking, "What am I going to do in there, if I'm not well". I mean, he was really ill, he looked terrible, and he was such a nice looking kid, he was sallow and grey-looking.
Q. Yes.
A. It was awful. So we -- I think we took him, didn't we, to Romford, give him the money --
Q. Yes.
A. -- for the train and some money for food to go to the -- because he wanted to go on his own.
Q. To court?
A. I think we got hoodwinked by him. I think that was his little plan to go there and not -- not go there.
Q. I understand.

A. And he ended up drinking with the money we gave him, and coming back to [redacted] where we was waiting.
Q. Yes, I understand and, as a result of that failure to attend the court date, a warrant was issued?
A. Yes, that's it, yes. That is where it all stemmed from, yes.
Q. Yes, so on 25 August, Essex Police came to your home looking for him?
A. Yes.
Q. You explained he wasn't there?
A. Yes.
Q. I understand that your husband spoke to police and said he would bring TJ in?
A. Mmm.
Q. But also your husband explained that he was extremely worried --
A. Yes, yes.
Q. -- because, between those dates, TJ had again been to a train station --
A. Yes.
Q. -- and talked about wanting to kill himself?
A. Yes.
Q. So that was explained to police by your husband on a call?
A. Yes, yes, definitely.

Q. He was due to have a probation appointment on the 25th.
A. Yes.
Q. And you drove him --
A. At 5.00, weren't it, I think.
Q. Yes, and you drove him to that?
A. No, no, I didn't drive him there.
Q. No, you didn't?
A. No, I didn't, did I?
Q. I'm so sorry.
A. Sorry, no, where are you? Did I drive him? No.
Q. No, you didn't, you are quite right, I am so sorry. The late appointment -- you are quite right, that's my mistake.
A. Sorry, sorry.
Q. Don't apologise for my mistake, my goodness.
A. Right.
Q. You're quite right. On 25 August, he had a later appointment in the evening, at which he did attend --
A. Yes.
Q. -- and the probation officer that TJ saw --
A. Yes, sorry.
Q. No, please go ahead.
A. I can't remember how he got there. I don't know if any of the girls took him or whatever, I can't remember. But I know he had that probation appointment. I thought

he had gone to that.

Q. Yes.

A. But, yes, you carry on from there. But, go on, that was at 5.00, but before that he had been playing up somewhere doing something and they said --

Q. Yes, when we got to his probation appointment, my understanding is that he was in severe distress?

A. Severe distress, yes.

Q. Explained to his probation officer that he had been to a carpark and that he had been thinking about jumping and she was extremely concerned?

A. He said he done -- I call it like a reconnaissance mission of the car park opposite Colchester Police Station, yes.

Q. Yes. She was concerned enough about the way in which he was presenting --

A. Yes.

Q. -- and what he told her that she suggested that he got to A&E.

A. Yes, she took him the lady she was working with at that time.

Q. Yes.

A. And that was about 5.00/5.30, in the car.

Q. Yes, in the evening?

A. Yes, yes.

Q. Yes. So she was concerned enough that she went with him?
A. Yes, she was concerned.
Q. Yes. They went together to A&E at Colchester General?
A. Yes.
Q. At the time, you didn't know about that, you got a call about it a little bit later?
A. Yes.
Q. So when you got there --
A. Must have been the probation officer must have called me, I can't remember, sorry.
Q. That's all right, you don't need to.
A. Yes.
Q. I will run you through it.
A. Yes, yes.
Q. Essentially, when you got there, they were all still in the waiting area of A&E --
A. Yes.
Q. -- and TJ had not yet been assessed; is that right?
A. No, he had been assessed I think, hadn't he? I don't know.
Q. All right, don't worry, I will stop asking you, having said I will run you through it.
A. No, it's all right. He said he had been a little room and he was sitting outside, sitting in a wheelchair,

just the two of them, still.

Q. Yes, I'm so sorry, I think you came slightly after that.

A. Sorry.

Q. No, it is my fault. Please don't apologise for my many mistakes.

A. No, no, no.

Q. He had been seen by a triage nurse, he said that he had been drinking and he was breathalysed?

A. Yes.

Q. The first suggestion was that he stay overnight in order to be assessed again when he was sober --

A. Yes.

Q. -- because he was presenting in a state of psychiatric crisis?

A. Yes, not drunk, because like -- sorry, the lady that took him, both of them said they couldn't tell he had had a drink.

Q. Yes, he wasn't slurring his words?

A. No, and I don't know --

Q. No.

A. I have tried, I have tried -- even that time, I have tried to look at the percentage of what they said.

Q. Yes.

A. And it still don't make sense to me that she said he was drunk and she couldn't assess him.

Q. Yes, I understand. So she said she couldn't assess him for that reason?
A. Yes.
Q. There was some suggestion from that nurse --
A. Yes.
Q. -- that he stay overnight?
A. In CDU --
Q. Yes. Go ahead.
A. -- which I have worked in, where I used to do agency shifts, extra shifts.
Q. Tell us what CDU is?
A. I can't remember what it's something -- oh, God, it had a nickname because it is something -- they used to call it something, dispatch and whatever.
Q. It's not a psychiatric unit --
A. No.
Q. -- and it's not staffed by mental health nurses, is it?
A. No, no, but they do put people in there that are drunk and need help, which is wrong, and if they kick off, they've got these burly security guards, and I've seen them mishandle people, so that weren't the place for him.
Q. No.
A. No.
Q. But, in any event, it never came to that. Because --

A. No -- they.
Q. -- what happened was --
A. Yes.
Q. -- and this is from your recollection --
A. Yes.
Q. -- there was a discussion about the fact that there was a warrant out for TJ's arrest?
A. Yes, that came after he said he could stay there.
Q. Yes, so that came after he had suggested that he stay overnight.
A. Yes.
Q. I know, and we are going to come to it, that that there is a big difference between what you recall about how that subject came up and what that nurse recalls about how that subject came up and what was done?
A. Yes.
Q. But sticking, for now, with your memory, as far as I understand it, your closer memory is that, as soon as she learnt that there was a warrant out for TJ's arrest, the nurse essentially said, "I can't assess him"?
A. "I can't assess him, we are not allowed to assess people with a warrant out for their arrest", so -- go on, I'm sorry.
Q. Were those the words, is that what you remember, that she said "We are not allowed"?

A. Something like that, she -- "I can't", what did she say, "I can't".
Q. It is all right, you don't need to remember the exact words. I am just interested.
A. Something about they can't assess them because he has got a warrant out for his arrest and that's when she just suggested that, as he had a warrant out for his arrest, I take him to Clacton Police Station and then he would get seen by the duty whatever they are called nowadays.
Q. The FME?
A. The duty surgeon, FME, that's it.
Q. It's the Force Medical Examiner.
A. That's the one, yes.
Q. So it is your clear recollection that what she said was "I can't assess him and I can't go forward because of the warrant" --
A. Yes, yes, "He's got a warrant out for his arrest and he needs to be seen by the police, take him there".
Q. What was your reaction to that, Karon?
A. That weren't going to happen, no, that ain't the place for him to go.
Q. Yes.
A. That's like 36 hours later, trying to kill yourself, they want to stick him in a police cell.

Q. Yes, did you have feelings at the time about whether or not police custody -- whether or not he was seen by a Force Medical Examiner, was the right place?
A. No, it's police custody, it's not the right place. No, it wasn't right place.
Q. Now, I understand that, during the evidence at inquest, the nurse who had been carrying out that assessment and having the conversation with you, TJ and TJ's probation officer --
A. Yes.
Q. -- seemed to suggest that it was your idea that he instead hand himself in to police --
A. No.
Q. -- and your evidence, I think, is that that is categorically wrong?
A. That's -- sorry, I can't even say that word. That's wrong.
Q. Yes. Was it a plan that you, or TJ, or TJ's probation officer positively agreed to, did any one of you say, "Yes, that's a good idea, we will take him down to the police station, instead"?
A. I think I might have said that.
Q. Right?
A. But not intending to take him, I took him home.
Q. Yes.

A. And then we was going to sort it out the next day.
Q. Yes, and, again, I asked you this in relation to the assessment that took place at The Lakes on the 9th, you having been told to take him to the police station, other than that, were you, or TJ, or his probation officer given any kind of information about how to help him, how to keep him safe, given the way in which he was presenting at the time?
A. No. No.
Q. All right.
A. Not at all, no. But could I just say --
Q. Please do.
A. -- the next thing --
Q. Please do.
A. -- that I can't believe what they knew, that they never told me when I picked him up?
Q. Say that again?
A. Is it right time it say it now?
Q. Of course, yes.
A. So basically the worst thing ever, that I can't get out of my head, that's led to me having, I think, PTSD, is that when I went to pick him up on Thursday, the 25th, they both knew that he had been up the carpark -- sorry, I've got to look at you now -- that he had been up the carpark on what I call a reconnaissance mission, and

they never told me.

Q. Yes.

A. The next day, I have drove him -- sorry.

Q. Take your time. It is all right, it is all right.

A. The next day, I've gone to work and he said he got an appointment with his probation officer.

Q. Yes.

A. And so that, that was that. So I took him most of the way, and he said, "No, it's all right, I'll walk", and I went to work. So I have basically dropped him off to his death, to go to the car park. But three times he did try and go into the probation office and she was busy and then, when I eventually got this through to her, when I finished work at 12.30, she said, "He's been in three times", even asked for a fiver to buy a t-shirt because he was hot because he had a tracksuit on --

Q. Yes.

A. -- and they -- he didn't go back.

Q. Yes.

A. And I said, "Oh, perhaps he's gone over to the police station to hand himself in".

Q. Yes.

A. So the probation officer, who was the same lady from before said, "I will ring the police station and get back to you", and he hadn't handed himself in, which is

directly next to the probation office, so he hadn't gone there.

Q. Yes.

A. So --

Q. I understand.

A. We don't know where he was, basically. She said if -- "When he comes in, I am sure he will come back, I will call you". So I have gone home, told Terry that we can't find him anywhere, something like that, whatever it is, and he was with his dad somewhere, I went down and picked them up, I was in my uniform.

I had got my phone and it was unknown, and I never do an unknown phone call, I never normally answer it, but I did because I knew he was not around, my son, and that was it, they said they was the police and they said "We are at your house".

Q. Yes.

A. Oh, and Terry said, "I think -- I wonder if he's had a fight and been injured, or something like that".

Q. Mmm.

A. And in my gut I thought, "Oh no, I bet he's gone under the police -- the train at the station at Colchester", and when we got there, I said, "He's done it, hasn't he, he's done it", and they said, "Yes, I'm afraid so", and that's when we walked to the house.

Q. Yes.
A. And I just, yes.
Q. Thank you.
A. Yes. So, and they had their chances but it just didn't arise to him getting a chance to be assessed properly.
Q. Yes. When you arrived at A&E on the 25th --
A. Yes.
Q. -- I think -- I just want to make sure that I have this really clear -- the assessing nurse knew that TJ had been on what you called a reconnaissance mission to the car park that day?
A. Yes.
Q. His probation officer knew?
A. No, the probation officer told her.
Q. Yes.
A. And --
Q. But you were not told?
A. And I was not told.
Q. So you left --
A. And I think -- I mean, whether -- they can't have forgot and they can't even -- she might -- the triage, crisis team nurse, but this one should have done --
Q. Yes.
A. -- the probation officer. She was really nice, TJ really liked her --

Q. Yes.
A. -- and they got on well. But of course he never kept appearing, had to keep going to her.
Q. Yes.
A. I was just so surprised, you know, they never told me. I wouldn't have gone to work if they had told me that.
Q. You wouldn't have gone to work the next day?
A. No, I don't know, I would have called an ambulance or something on the Friday with Terry and say, "Look, he's been up a car park on Thursday, twice he's been to railway stations".
Q. Yes.
A. Sorry, Terry is my husband. I didn't say, did I? He could have been anyone, couldn't he?
Q. That's all right. No, there is nothing to say sorry for. Karon, we do need to take a short pause.

Chair, we do need to pause for a moment, just because, as you are aware, staff names, including those of junior staff, will generally be disclosed in the course of the Inquiry but individual staff members may apply at a later stage to have their names withheld.

To allow staff time to decide whether or not they want to make that application, you have directed temporarily that their names be restricted, and I understand that a staff name has now been mentioned,

which is completely understandable during the pressures of a hearing, but just to ensure that we maintain fairness at this stage, I need to draw your attention to it and just ask you to confirm to the room and those watching via the secure link that a restriction order is in place and that they must not repeat the name of any staff member which they have heard within this hearing. In the background, it will be arranged that the YouTube feed is paused and that that reference is removed from that feed and from the published transcript.

THE CHAIR: Ms Troup, I confirm that I have made that restriction order and that that restriction order applies.

MS TROUP: Thank you. Sorry about that.

A. Sorry. I know who you was referring to now.

MS TROUP: That's all right. I have to be honest, I didn't even notice, Karon, so I am very grateful to the gentleman sitting beside me, because I was listening to you. Please don't worry about it.

A. I won't do it again.

Q. You are already under pressure, so please don't worry about it.

What I want to go on to, I think I -- what you say in your witness statement is that, although you didn't know it when you left the hospital with TJ on 25 August

2016, the assessing member of staff knew and could see and was told that TJ was in an active state of suicidal crisis?

A. Yes, yes, that was what the probation officer obviously told her when she took him there.

Q. Yes. To you, and you tell me again if I am summarising it wrongly, Karon, or in the wrong words, it was just utterly shocking and confusing that a nurse would say, "There is a warrant out for his arrest and therefore I am going to step away and you must take him to the police"?

A. Yes.

Q. This just made no sense to you?

A. No. Not at all, no.

Q. It seems that really what was being said to you is that involvement with the criminal justice system and with criminal proceedings somehow prevented TJ from being treated --

A. Yes.

Q. -- clinically?

A. Mmm.

Q. What comes across very clearly in your witness statement is that it's very obvious to you which of those two things ought to be the priority --

A. Yes.

Q. -- and that the one is not a barrier to the other?
A. Mm-hm.
Q. Is that fair?
A. Yes, yes, 100 per cent. Yes.
Q. This series of events at Colchester A&E was also looked at by the two experts who were instructed in relation to the civil claim, and I just want to take you briefly to what they said. If you want to look at it, Karon, I am looking at page 32, and at the very top of the page?
A. Mmm.
Q. If it's all right with you, I would like it read that section --
A. Yes.
Q. -- of this expert's report?
A. Yes.
Q. Both experts were highly critical of the decision to discharge TJ on 25 August in that way and for that reason.
A. Mmm.
Q. One of the experts says, explaining that that was a wholly unreasonable decision, is this:
"We have here a situation where a man who has just been brought to the Accident and Emergency Department because of fears for his safety is sent back into the community without any support and in an intoxicated

state. I am of the opinion that there is no reasonable body of mental health nurses working in the same role who would have taken the decision to allow TJ to leave hospital."

A. Mmm.

Q. That's pretty powerful, isn't it?

A. Yes, yes.

Q. What the experts went on to say is that one of the most egregious aspects of that discharge was some sort of rigidity around sticking to some sort of protocol which really was non-existent --

A. It's not in the policies and procedures, I can assure you, no.

Q. -- yes -- about saying that he couldn't be assisted because of the existence of a warrant?

A. Mmm, or intoxicated. It's like, if you walked in with appendicitis, would they say, "Have you been drinking, I can smell drink, go home, get sobered up". It's not --

Q. Yes.

A. -- it's not the done thing, is it, really?

Q. Yes, and, to you, this is just unfathomable?

A. No, that's why I can't get over it, no, no, no.

Q. Yes, I understand. I would like to take you now to some of what the nurse who assessed TJ on 25 August said in

her evidence at inquest, which I think was a matter of particular -- it was particularly distressing to you.

One of the things that I understand is that you were shocked and confused by that decision to discharge TJ at that stage --

A. Mmm.

Q. -- but that one of the things that was said in her oral evidence, in front of the coroner at inquest, was that she felt confident that TJ would keep himself safe because he had kept himself safe all day. What are your thoughts on this or what were your thoughts on that at the time?

A. Well, she, she's -- she is not in the right job, is she, really?

Q. Because of course --

A. Because she's a senior, as well, so ...

THE CHAIR: Did you form a view about what was motivating her when she suggested that she would not be assessing TJ?

A. Did I? Well, she had. She had had the chance to assess him but there was no paperwork again, was there, I don't think? Was there very little --

MS TROUP: That's right.

A. -- A&E paperwork as well.

Q. Yes, that is right.

A. The same as Goodmayes, The Lakes, and A&E in Colchester, very little notes. Again my -- I don't know, I don't know really. Perhaps it could have been personal things that had gone on in her life that may have affected her judgement.

THE CHAIR: So she said nothing to give you any understanding of what was really behind --

A. She was very harsh, let me put it -- hard and harsh, that's how I would describe her.

THE CHAIR: Thank you.

MS TROUP: That's really helpful. The impression I have from your witness statement and from the information you have provided to us is that it was almost as soon as that was mentioned, that there was a warrant, a sort of barrier came down, and, "Now I am stepping away and I can't assist you".

A. Mmm.

Q. I think one of the things you say very clearly in your witness statement is that, especially given your own career as a nurse, that it is so clear to you that what should be the priority in all cases is clinical need --

A. Yes, yes.

Q. -- and clinical presentation --

A. Yes.

Q. -- and that's what was so shocking to you?

A. (Witness nodded)
Q. But, of course, at the time, you were also in the role of TJ's mother --
A. Yes, yes.
Q. -- and desperately trying to protect him --
A. To help him and protect him.
Q. -- and get him safe?
A. Get him home to where we could look after him, not send him to Clacton Police Station.
Q. Yes.
A. There's also one thing that -- I think sometimes I felt she wanted to get off work, as well, 8.00.
Q. I see.
A. I was trying to work out the times, which I can't, and I sort of remember -- I know because the other one had to go, the probation officer had to go quite early because she had to pick her kids up by 8.00 for her husband to go work or something.
Q. I see.
A. And it was then I thought 8.00, yes, I bet they do 12-hour shifts, and I bet either -- I might be wrong.
Q. Mmm.
A. But I'm not silly. I think she thought, "If I have got to do all the paperwork, I am not going to get home until 10.00".

Q. I understand.
A. It might have been. I am not saying it is, it might have been time constraint, perhaps.
Q. I understand. One of the other things I wanted to talk through with you a little bit, Karon, is the way in which you and you as a family were engaged with, or not, by staff in the round across both of the two incidents that we have been talking about, on 9 and 25 August, and we have talked through, I think, in some detail the fact that there was just no -- there was nothing at all and actually you have put it so well in your witness statement. There is a section here, where you say that one of the Rule 9 questions this Inquiry put to you was whether you felt that you had been listened to and what you say here is:

"In order to be listened to, it requires a person to have a conversation with you."

A. Yes.
Q. Your point is that that never even got off the ground?
A. No. He's 30, isn't he?
Q. Yes.
A. There's still -- there was that barrier there as well, because of his age, and me -- well, they never told me -- that's the thing, I can't understand, that he'd been up the day -- that just still don't make sense and

will never.

Q. Yes.

A. I would like to ask them one day why they didn't tell me that day, but it's never going to happen.

Q. I understand. One of the things -- I think you saw the Serious Incident Report that was carried out, that was produced by the Trust following TJ's death, and we will talk a little bit about that, the word that you use in relation to it is "whitewash". You see it as finding no particular criticism of any -- there is no particular criticism of any kind --

A. No.

Q. -- of any of the events that you and I have just been through?

A. Mmm.

Q. I think one of the things that you found particularly upsetting, I understand that in the report, talking about the assessment at The Lakes on 9 August, the nurse who carried out that assessment, when asked why there was no engagement with you, the answer given was that there was no legal obligation to engage with you?

A. Mmm.

Q. To you, that is not a matter that should have been based on a legal obligation. You were desperately trying to provide information about your son?

A. It's not written in stone. We know that we have got that 18-year-old thing or a 16-year-old thing, but it is not written in stone, is it, that you can't talk to the mothers of people that are seriously ill?
Q. Of course not.
A. Or fathers, whatever, just ...
Q. And you as a nurse, and I think this also comes across in your witness statement, know that where someone is very unwell one of the key routes to finding out more about that is through --
A. Yes, you question the family --
Q. -- the nearest relatives --
A. -- or whoever brings in them in unconscious. You've got to ask someone, you can't just say -- because they won't have the records, they could be 200 miles away on holiday.
Q. Yes.
A. So if someone brings them in and they are unconscious, what are you going to do?
Q. Yes. In relation to that report, just coming back to that -- forgive me, yes -- what you say here is that you consider that report to be a cover up of errors and a whitewash, and I am looking, Karon, if you want to have a look at it, you don't have to --
A. Yes.

Q. -- at page 28 and paragraph 130. There, what we find sort of rehearsed, which is one of the major issues that as we have discussed was going wrong in the first place, is that in this investigation report, there is a focus on TJ's problems with alcohol?
A. (Witness nodded)
Q. To you, that's actually deeply insulting because that's one of the problems with the assessments in the first place?
A. In the first place, yes, yes.
Q. Yes. Karon, in terms of those two, the assessment at The Lakes on the 9th and the failure to assess or the refusal to assess on 25 August 2016, is there anything else that you want to say about either of those incidents in terms of the impact on you as a family or on TJ and what you think it meant for him? You have spoken a couple of times now about obvious missed opportunities?
A. Yes, yes. I don't -- I don't know what to say really.
Q. Okay.
A. It's just, it's ruined -- it's -- you think, we have got two girls that we don't see now. I have got four grandchildren, I don't see none of them, and this is none of our fault but it's just brings -- it don't bring families together, it tears them apart. So it is just

me and Terry now --

Q. Yes.

A. -- living in a one-bedroom flat because we lost our house, four-bedroom detached house. We are in a one-bedroom flat, which I love anyway, it's better, and don't see the kids. And they are very touchy, I only have to say one thing wrong and don't agree with one of them, and you are finished. So they will not see you for a year or six months. It's terrible.

Q. I understand.

A. I don't know. They have just turned against us and they don't know, it ain't our fault: there you go.

Q. Thank you. In general terms --

A. I don't know what else -- I lost my way with the question.

Q. Yes, it is all right. It probably wasn't a very well phrased question, that would be the cause.

I think, in general, your feeling is that these were the most serious of failings and the most severe failures to assess properly --

A. Yes.

Q. -- at a time when, actually, he could have been assisted?

A. Could have been, yes.

Q. Is that fair?

A. Yes, if I was there, if I was that triage mental health nurse, I would have sectioned him there and then and walked him across The Lakes.
Q. Yes.
A. The other thing that there might have been, there was no beds and then they might have had the trouble, you know. There's loads of things that I can think of --
Q. Yes.
A. -- that she must know --
Q. Yes.
A. -- that might have thought, "Oh, God, if there is no bed, what we are going to do with him then, but he's got a warrant, he's had a drink". I don't know what she was thinking.
Q. These things play on your mind, I think, as sort of possible explanations?
A. Yes, all the time. Near enough nine years later, I just go -- I have nightmares about the car park. It's terrible.
Q. Of course.
A. Mmm. And the other thing that I have nightmares about is did he suffer, because I know a helicopter landed and they was working on him, so -- and I have attempted to go through the police -- ambulance and get a report and then I back out of it because I don't know if I want to

know --

Q. Yes.

A. -- because I know his injuries was severe but for them to try and save his life, what did they do to him --

Q. Yes.

A. -- on the sidewalk of [redacted], a helicopter 50 yards away, I don't know.

Q. Karon, I am so sorry.

A. No, that's just ... I would like to know but I won't know because I think if I did that that make it a lot worse. I am just thinking he was probably dead but he had a pulse or something. Sorry, I shouldn't.

Q. That that's all right.

A. I'm thinking as a nurse.

Q. You don't need to apologise. Of course you are, you are thinking with your own professional experience --

A. I don't need to, sorry.

Q. -- behind you.

How are you doing? We could either take a very short break now, if you would like a few minutes, and then we are going to come on to talk about your recommendations for change and the things that you would like to see action taken about. Do you want to take five or ten minutes now or are you happy to go on?

A. If it's not going take long, I will carry on.

Q. Of course, it is up to you. All right. So it might I think it might help you to look at these but you don't need to. Again, we can talk through them.

I am now looking, Karon, at page 38 of your witness statement, and I am looking at the very first paragraph there, which is paragraph 154?

A. Yes.

Q. Here you make the point that has been running through every single aspect of what we have discussed about TJ's care, which is that there has to be more involvement --

A. Yes.

Q. -- with the family in these situations?

A. Yes, 100 per cent. Yes.

Q. You explain again that TJ was incredibly skilled at masking his struggles to protect other people or because he was afraid or whatever it was --

A. Yes.

Q. -- as is so often the case and, very helpfully, I think partly because of your professional experience, you also say here that what you would recommend is that, if someone is having a mental health assessment, it should be standard practice at least to have a meeting with family or nearest relatives, or whoever it is, before that person is discharged.

A. Yes.

Q. You also say that it is crucial for an appropriate plan to be in place, so that there isn't any risk-relevant information missed, as in exactly what happened to you on 25 August when you drove away not knowing --

A. What he had been up to in the day.

Q. -- the state that TJ had been in the day before?

A. Mmm.

Q. You also recommend that mental health trusts should have a standard protocol in place for how and at what stages they engage with family members?

A. Yes.

Q. On that --

A. Yes.

Q. -- and given everything that we have been through, on that particular point, is there anything else that you want to add or that you want Baroness Lampard to hear?

A. What bit was that, sorry?

Q. I am so sorry, this is paragraph 154 --

A. Yes, yes.

Q. -- at the top of 38, and this is where you are making your recommendations about how families should be involved in mental health care and, in particular, at the assessment stage.

A. No, I think that covers.

Q. I think it does.

A. Yes.
Q. I think it does but I am just checking. I don't want you to feel that you have missed anything?
A. No, no, that's all right, thanks.
Q. The next point that you make, and we have talked about this a little bit, is that you say very obviously that someone who happens to be subject to criminal proceedings should have exactly the same rights to be assessed and treated by clinicians as anyone else?
A. Walking in, yes, yes.
Q. The way it's expressed here -- I mean, you have said that the nurse's belief that she couldn't assess on the basis of a warrant was entirely mistaken.
A. Mmm.
Q. But that what it shows is that there is some kind of fundamental misunderstanding as to what the priority is for a clinician who is presented with a young man in psychiatric crisis?
A. Yes, yes. I mean, do they -- is that part of their training, do they know about it. I don't know, I don't even know if that's in -- are they trained to -- I don't know if they ever bring that up in their training. I mean, she was an experienced one as well, the one that was there.
Q. Yes, you said.

A. You'd think she'd have known.
Q. You also do go on to say that you have concerns about staff training and I am looking at paragraph 157 of your -- that's page 38?
A. Oh, yes, yes. That's just --
Q. You said --
A. That's just part of my training.
Q. It is very helpful.
A. I started from Covid and now it's just carried on. So you do your yearly assessments, three yearly assessments --
Q. Yes.
A. -- and all of it's done on a computer.
Q. Yes.
A. I've seen a lot of girls doing it at work, I think I have even done it myself when I was quiet and when someone gets stuck, someone else says, "Oh, I got stuck on that one, it's A", and you know, it's -- and at the end you have to pass by 80 per cent.
Q. Yes.
A. Then you just keep doing it until you get to 80 per cent or above.
Q. Of course you do, and it becomes repetitive --
A. No one pulls up, if you keep get 50s and 50s, they don't think to themselves, "Oh they haven't really got it,

they haven't really watched it", because some of the videos are like 30 minutes long, then you are asked questions on it.

Q. Yes.

A. And that's on everything.

Q. Yes, so that kind of online training leads to -- I think the way you have put it is a lack of accountability around whether or not that training has really embedded --

A. Yes, yes.

Q. -- and whether people have really done it --

A. Yes.

Q. -- and really understood it --

A. It is ridiculous.

Q. -- in terms of actual day-to-day practice?

A. It is stupid, and it's a yearly thing for some things, three yearly for other things but ... it's just an ABC.

Q. Yes.

A. And comments, it always asks for comments, but no one does it, "Give your reasoning why", it says.

Q. Yes.

A. No one does it, we just click for the next question, and no one's ever been pulled up about it because no one looks at it.

Q. I understand.

A. You see what I'm saying?
Q. Nobody is checking it?
A. It is just a data thing: Karon has done this, Karon has done that, she got 80 there, 70 there.
Q. So it is a tick box sort of the exercise?
A. Yes, yes.
Q. I think what you are saying is that there are some key areas and fundamental areas of clinical practice where training should be face-to-face --
A. Classroom-based, yes.
Q. -- and it should be done in a completely different way?
A. But what they will say is they haven't got the staff to do that, to let them go off the ward.
Q. I see.
A. So ...
Q. One of the other things that you say, and we are coming to the end of what you say about recommendations now --
A. Yes.
Q. -- and I am looking at the bottom of page 38 and then your last page on page 39.
A. Yes.
Q. Here you talk about the reports that are issued by coroners --
A. Yes.
Q. -- to prevent future deaths?

A. Yes.
Q. That did happen in TJ's case?
A. Yes, yes.
Q. Yes?
A. A big -- it was a big -- a lot of things.
Q. Yes. The Prevention of Future Deaths letter that went to the Trust received a response, and you make an important comment here about the response to that letter from the Trust. So when the coroner wrote her Prevention of Future Deaths report, the Trust came back -- I am just looking at paragraph 159 -- and said:

"Please be assured that learning from Mr Pimm's death is being shared across all the new trusts to help prevent the same issues arising again."

A. Mmm.
Q. Karon, you say there that, to you, that assurance was then and remains now an empty one?
A. Yes, because it still happened in the same Trust. You look every week at the news, in our places it's always something, one week to two weeks, it's still EPUT.
Q. Yes. You have pointed out that you think there needs to be very substantial changes in terms of the monitoring of whether or not, when a coroner makes those kinds of recommendations, they are actually implemented?
A. Yes, you know, the policies and procedures are they

changed -- should I give them a time. As I said -- can I carry on because this was my brain thinking?

Q. Please carry on, I want you to carry on.

A. So what I say is you have got the CQC, yes, so as a general nurse, we know they are coming, they come, tidy up, do this, do they. They all get ready, it is all rubbish, they all make sure you are up to date with your training and blah, blah, blah.

But with them, they are not worried about the other side, are they, they are not following up on -- I think, Prevention of Future Deaths, yes, they send it to the Trust but the Trusts aren't acting upon it. So I think the CQC should have a different a little section department to get -- sorry, I am all hands.

Q. Go ahead.

A. They should have departments to deal with the Prevention of Future Deaths and follow up on it, like they would, and give -- yes, not that could bring them down to a negative score, they give them scores of good, blah, blah, blah, but you never hear of -- I have not heard of a mental health hospital really being given that standard. I don't know, they probably do, but I am not -- I am getting mixed up now, sorry.

Q. No, I don't think you are at all. It is such an important point.

A. Yes.
Q. One of the things you are saying is that, given the time and money and the trauma for families that goes into the inquest process --
A. Yes.
Q. -- and then into the coroner --
A. It's just --
Q. -- writing that report to try and prevent future deaths --
A. Yes.
Q. -- you feel very strongly that that's such a waste of a process, if it's not then --
A. Implemented.
Q. Yes.
A. Exactly, then that's when you are not going to get changes.
Q. Yes.
A. Because -- yes.
Q. I understand.
A. The NHS is funny, anyway, isn't it, so it's hard. Policies and procedures, though, you know, do they get changed? So I don't know. Probably not.
Q. As we have been talking through your evidence today, in terms of what you would like to see done differently and changes, is there anything else that you want to mention

at this stage?

A. No, I don't think there is. I think that's okay.

Q. All right.

A. Yes.

Q. Karon, what we are going to do, I have come to the end of my questions for you --

A. Yes.

Q. -- and unless the Chair has any questions for you now --

A. Yes.

Q. -- what we will do is that will conclude your evidence and we will take just a very short break to ensure that there are no other questions for you or that you don't think of something else you want to mention but, if there isn't anything, if there aren't any further questions or you have nothing else to mention, then I won't call you back.

A. No.

Q. So I am going to say that this concludes your evidence but, before you leave the witness box, I am going to ask that the photograph you provided of TJ be put up on the screen --

A. Okay.

Q. -- just so that everyone who has been listening to your evidence can see again who we are talking about.

A. Yes, okay. Yes, yes. That was -- he was premature,

2lbs.

Q. 2lbs?

A. Mmm.

Q. My goodness.

A. It's a long story. You don't want to hear it. I had major surgery when I was first pregnant with him as well.

MS TROUP: I do want to hear that longer story.

THE CHAIR: Can I take the opportunity to thank you very much indeed for coming to give evidence. It's obviously not an easy process --

A. No.

THE CHAIR: -- and I hope you feel you have been able to --

A. Help the future people.

THE CHAIR: -- tell us what you wanted to and to be assured that we will take account of what you have said.

A. Yes, yes.

THE CHAIR: So thank you very much.

A. Thank you. Lovely to see you again, thank you.

MS TROUP: Thank you.

A. Thank you.

(11.50 am)

(A short break)

(12.15 pm)

THE CHAIR: Ms Lea.

MS LEA: Good morning, Chair. We will now hear evidence from Mrs Carden who will be sworn in.

JANET CARDEN (sworn)

Questioned by MS LEA

THE CHAIR: Yes, thank you.

MS LEA: Can you state your full name for the record, please?

A. Janet Marilyn Carden.

Q. Mrs Carden, you are giving evidence today about your brother, who was born on 29 September 1957 and died on 17 February 2015 at the age of 57, whilst under the care of North Essex Partnership University Trust; is that right?

A. Yes.

Q. I will be referring to your brother as "your brother" or "W4" throughout these questions, as you have been granted a restriction order at your request in respect of his name. But, as I understand it, you are happy for us to discuss personal details in relation to your brother's treatment and death and understand that this is a public hearing?

A. Yes.

Q. You would like me to call you Mrs Carden; is that right?

A. Yes.

Q. By way of background, the Inquiry sent a Rule 9 request

for evidence to your legal representatives on 19 March this year and, in response to this request, you have provided a witness statement. You hopefully have a copy of that witness statement in front of you in a red binder, it is an 11-page statement, it's dated 15 May this year.

If you could turn to the last page, please, page 11, we see there that you made a statement of truth and you signed your witness statement.

Have you had an opportunity to read through that document recently?

A. I have.

Q. And you are happy that it's accurate to the best of your knowledge and belief?

A. Yes.

Q. That witness statement, as you know, Mrs Carden, will stand as your evidence to the Inquiry. Although I am going to ask you questions about the statement, we won't go through it line by line together and I won't ask you to read it out word for word?

A. Okay.

Q. But please be assured that the Chair and the Inquiry team have read and considered the entire statement very carefully and it will form part of the body of evidence upon which the Inquiry will rely.

I would also like to acknowledge that you have provided a commemorative and impact account in relation to your brother, however that will remain private as per your request. The Chair has of course carefully considered that account, as have I, and we are grateful for it.

I remind you I won't be asking you to name any individual staff members or experts, so please do not do so.

Your evidence today will focus on your concerns in relation to your brother's care and treatment under the care of NEPT. If at any point you require a break, please do flag it to me. My intention is to take your evidence for about an hour, and check in with you, see how we are going, if you would like to continue.

You are clear in your witness statement that the dates and events that you have set out therein come from your knowledge but also any documents that you might have seen after your brother died?

A. Yes.

Q. Before we begin, I would like to set out that brief timeline of your brother's involvement with Essex mental health services. I will summarise key dates taken from your statement. Please do stop me if you feel that I have summarised anything incorrectly and please feel

free to refer to your witness statement as you wish throughout my questions.

I will then move on to your concerns and, ultimately, recommendations for change for the future.

As I understand it, according to your statement, your brother had a long-standing history of mental health problems since 2002; is that right?

A. Yes, it is.

Q. Notably, he was diagnosed with recurrent depressive disorder, around about 2004, triggered by a brain aneurysm surgery in 2000; is that right?

A. Yes.

Q. You note that he had several hospital admissions in mental health units before he died on 17 February 2015. On 7 November 2014, you state that he was diagnosed with generalised anxiety disorder; is that right?

A. Yes, I believe so.

Q. Is it right that that was during an admission from the 7 to 20 November 2014 to Galleywood Ward at the Linden Centre?

A. Yes.

Q. Do you know whether that was under section?

A. I know that it wasn't.

Q. In December 2014, you state that he was readmitted to the Linden Centre as he reported he wanted to end his

life. Was that an admission on 24 December to Finchingfield Ward at the Linden Centre?

A. Yes.

Q. Are you aware whether that was under section?

A. I am pretty sure it wasn't. He knew how ill he was.

Q. Would you like to say any more about that. You say he knew how ill he was, could you just explain a little to us what you mean by that?

A. He had struggled with his condition since 2002 and, if he was feeling poorly, he would contact us and come and stay, sometimes for a few nights, sometimes for longer, and he was -- he made several attempts before and he was very aware that his condition was dangerous.

Q. Can you just explain to us a little how that links to whether or not he was under section?

A. I wasn't there but my husband was and he was knowledgeable in this field because he had worked in a mental health trust for nine years and he came away and he said, "They would have sectioned him had he not been so compliant and so understanding of his illness". He was an intelligent man, he knew he was ill.

Q. Are you suggesting, and please correct me if I am wrong, but are you suggesting that he knew what to say in order not to be sectioned but to remain informal?

A. He knew that if he was compliant and he accepted the

offer to go into the ward, he knew that if he went in and he wasn't sectioned, he would be more free to come and go.

Q. Thank you. Returning, if I may, to the timeline of events. You state in your witness statement that, on 20 January 2015, he attempted to hang himself whilst he was still an inpatient at the Linden Centre; is that right?

A. Yes.

Q. And that he remained an inpatient there until discharged on 2 February 2015?

A. Yes.

Q. He was then readmitted two days later?

A. Yes.

Q. To Finchingfield Ward back at the Linden Centre on 4 February 2015?

A. Yes.

Q. On 5 February, the following day, he was prescribed recommencement of a drug that he had previously taken and advised that that could cause severe suicidal ideation for 14 days thereafter --

A. Yes.

Q. -- is that right?

You note that on 6 February 2015 he reported feeling suicidal to staff; are you able to tell us a little more

about that?
A. On the 6th --
Q. On 6 February, so the day after he recommenced the antidepressant medication that he had previously been taking.
A. No, I don't think I can.
Q. Okay.
A. I mean --
Q. That's not a problem.
A. -- he was constantly telling us and them about the thoughts that were running through his head. I'm not sure that they understood what he was saying or listened to it. They thought he was attention-seeking.
I mean -- yes.
Q. Is that a view that he expressed with you at the time or is that a view that you have formed, having read documentation that you now have?
A. It's a view that I have formed and it was the view of my husband, that the staff did not understand that he was not attention-seeking; he was genuinely suicidal.
Q. Thank you. You further state in your witness statement -- and, Mrs Carden, I am at paragraph 10, if you would like to follow along, but you are not obliged to in any way, just so that you know where I am --
A. Yes.

Q. -- in your statement -- around 6 or 7 February your brother texted you to say he wished he was dead and your husband reported that to the staff at the Linden Centre but that wasn't recorded anywhere; is that right?
A. Yes, yes.
Q. On 12 February 2015, he was permitted to leave the ward unaccompanied to get tobacco and he in fact went to Chelmsford; is that right?
A. Yes.
Q. That afternoon, on 12 February, he was on hourly observations, during which he self-harmed by scratching his arms?
A. Yes.
Q. Later that day, he was able to use a lighter to create a ligature, he stood on a weight-bearing 45-centimetre bin in the shower room and ligatured from the bathroom door. You state that CPR was commenced but no treatment was effective and, sadly, he died on 17 February 2015; is that right?
A. I was told that CPR was commenced. I was -- obviously we weren't there.
Q. Right. Thank you. Are you happy with that brief summary of the key chronology and events?
A. Yes.
Q. We can now turn to your concerns.

Thank you. I would like to ask you some questions, first of all, in relation to your concerns regarding your brother's repeated discharges?

A. Uh-huh.

Q. So we now that your brother was discharged on 20 November, then readmitted on 24 December, then discharged on 2 February and readmitted two days later.

You ask in your witness statement why he was repeatedly discharged when he was clearly so severely mentally unwell. Have you ever been provided with a reason or explanation as to why he was repeatedly discharged in quick succession?

A. Not from the staff. He mentioned that the ward was busy and, at one point, he actually took another patient home with him for the weekend. In fact, I think maybe even two. It didn't work out because he was too ill. He couldn't cope with having visitors at home.

Q. So he took patients home with him to stay at his home?

A. He took at least one, and I believe it was two, to start with, patients home to stay. He was an incredibly friendly and generous man.

Q. On the last occasion where your brother was discharged, on 2 February, can you recall, were you or your family involved in that decision to discharge him at all?

A. No.

Q. Can you recall, were you invited to a discharge meeting or anything of that nature?
A. I don't recall it. My husband may have been but I don't remember. Usually, we would just get either a visit from him or a text saying that he had been discharged, and it -- I have to say, it was incredibly worrying because, as well as the frequent times he was allowed to leave the ward for various things, these discharges really, I believe, got in the way of the staff getting to know him. Because a lot of the time, during the day, he wasn't there. It was kind of like a dormitory place.
Q. Understood. Can you recall if you were provided with any information, explanation or reason as to why he was being discharged on 2 February?
A. No.
Q. Any information as to warning signs perhaps to look out for, what to do in the event of crisis?
A. No. My husband was an expert, we knew what to do, if there was a crisis. In fact, we had stopped three previous attempts between us.
THE CHAIR: What was your husband's role, specifically, when he worked at the Trust.
A. He was a hospital -- he was in charge of the chaplaincy, so he was in charge of a team of chaplains who worked across the hospital and I believe also at St George's at

some point.

Yes, so he spent a lot of time on wards --

THE CHAIR: Yes.

A. -- supporting staff and patients.

MS LEA: Do you know on that occasion, again 2 February, what plans were in place for treatment in the community and follow up?

A. I believe he was given a contact name for the community mental health team, contact number, and we had that number as well, in case we were concerned. But I don't think that they had been in touch with him before he panicked and asked to be back on the ward.

Q. So turning to that then, the readmission on 4 February. Can you tell us a little about the circumstances of that readmission. You say he panicked and asked to be readmitted?

A. Yes. He, he just got very distressed and felt that he wasn't well and that he needed to be looked after.

Q. So was it you that contacted a clinician to make them aware of that or the crisis team, can you recall?

A. I'm sorry, I don't remember.

Q. No, that's okay. I would like to ask you some questions about your brother's diagnosis, if I may.

A. Mm-hm.

Q. In your witness statement at paragraph 4, you state that

he was diagnosed with a generalised anxiety disorder during the admission in November 2014. You then go on at paragraph 5 to say that, during the admission in December 2014, his diagnosis was mixed anxiety and depression, with a background of a long history of severe recurrent depressive disorder?

A. Yes.

Q. So is it your view that the diagnosis of generalised anxiety disorder was incorrect, that was a misdiagnosis?

A. I have done some reading and the opinion seems to be that anxiety was a symptom of the severe recurrent depressive disorder and not actually what was his condition, and that that's an enormous problem because anxiety and depression carries a very low rate of suicide, whereas recurrent depressive disorder is -- carries a very high rate of suicide.

So, you know, if the nursing staff were under the impression that he was in because of anxiety, that would explain their feeling that he wasn't a suicide risk, which was what came out at the inquest. Several of the nurses said, "We didn't think he would do that".

I mean, that -- to us, that was crazy because that was the only reason, after weeks living with us, that we asked for him to be admitted because we could not watch him 24/7. Yes. So it was, it seems to have been

a disparity between what the medical staff understood his condition to be and what the nursing staff understood his condition to be.

Having said that, I think the person who was acting as consultant on the ward at that time was also under the impression that he was suffering from anxiety and depression and, yes, many of [W4's] conversations with that person were about his car, not about his thoughts, his feelings, what was going on in his life, the distress he was under.

Q. So your view, based on the reading that you have done and the findings at the inquest, was that the correct diagnosis was severe recurrent depressive disorder --

A. Yes.

Q. -- with symptoms of anxiety?

A. Yes.

Q. You have just explained to us the impact that you feel that had in terms of the level of risk and the misapprehension that he was therefore lower risk; is that right?

A. Yes, yes. Yes. He was, he was actually assessed as being at low to moderate risk at some point during his stay --

Q. Yes.

A. -- which was, to us -- I mean, had we known, was crazy.

Absolutely crazy.

Q. I would like to come on to the risk assessment process in a moment --

A. Okay.

Q. -- if we can?

A. Yes.

Q. May I touch on medication first?

A. Of course.

Q. You state that -- at paragraph 6 of your witness statement -- in your view, your brother wasn't treated correctly in that he was not medicated according to his actual mental illness. Please can you explain a little more about what you mean by that?

A. As I understand it, what happened was he had been on paroxetine for a long period of time. That had side-effects that were not to his liking and I think, before he was admitted, in other words probably before he came to stay with us, his medication had been changed by maybe a GP. I'm not sure.

That -- all these medications take time to have effect. So you are on them for weeks before anybody makes a decision that they are effective or not and, during his first admission, I don't know what the medication was, but it had been changed, it wasn't paroxetine. And then at that last, after that last

admission on 4 February he was put back onto paroxetine, which had always been effective for him.

The problem with that drug is that it carries a very high rate of suicide during the first two-week period, and possibly a bit longer. [W4] knew this because he had been on that drug for a long time, for years, and of course my husband knew it as well, and they actually had a conversation about how the next two weeks were a period in which to be careful, and I think my husband used the phrase "Stay in touch", so that we knew what his mental state was.

However, as I understand it, the staff didn't increase his observation levels or take any particular care or in any way seem to be aware that the two weeks, from the start of that drug, were going to be a danger period.

Q. I think --

A. I would just like -- sorry -- further on medication, I would just like to say he was also prescribed something, I believe, to help him sleep, on the PRN basis, which is the "as required" basis.

Q. Yes.

A. [W4] had -- he had many -- oops -- strategies.

MS LEA: Will you just pause for one moment.

Chair, we are just pausing the live feed for

a moment. As you will be aware there is a restriction order in place in respect of the deceased, so if we could perhaps remind everybody in the room that we cannot publish the name of the deceased and I will ask Mrs Carden to restart her evidence at the beginning of that question.

THE CHAIR: And I will confirm that that restriction order is in place.

MS LEA: Thank you.

Mrs Carden we were just talking about medication and you referenced PRN medication.

A. Okay.

Q. Would you like to tell us a little about that?

A. So his strategy for sometimes dealing with difficult thoughts was lots of exercise -- he would run for miles or cycle for miles -- a big meal and sleep, and that PRN, obviously, was crucial.

Obviously, on the ward, the exercise wasn't available. We took food in every day, in addition to what was available, because it wasn't enough, and the PRN should have been given when he asked for it, but it wasn't. And that upset him, I have to say, because that was his prop and, had he been at home and had that medication, he would have been able to give it to himself. But because you are on a ward, it's under the

control of the staff and the staff would say things like, "Yes, in the next medical round", or, you know, the next medicine round.

Q. Was that during his final admission from the 4 February onwards, or are you referring to his admissions generally?

A. I am referring generally.

Q. You further explain at paragraph 6 of your witness statement that you pursued a clinical negligence case against the Trust and two experts were critical of the care your brother received. You also state you might like the opportunity to provide a supplementary statement in relation to those reports, once consent has been obtained from those experts.

So I won't ask you any questions specifically about those reports today.

A. Okay.

Q. However, turning to discuss risk assessments and we have already alluded to this a little in your evidence, it's very clear that when your brother was readmitted to the Linden Centre on 4 February, he was recorded as low to moderate risk of suicide. You ask in your witness statement how someone with a history of self-harm and suicide attempts could be noted as low to moderate risk.

Is it right, therefore, that, in your view, he

should have been considered as high risk for those reasons and also the one that you have alluded to earlier, which is the fact that he had restarted that medication with a known increased risk?

A. Definitely. I mean, that was the only reason we ended his stay with us and got him into hospital because we knew that we could not watch him 24/7. It needed -- it needed professional staff.

Q. Can you recall, were you as a family asked to provide any thoughts or information to assist with any risk assessment process that went on when he was admitted on that occasion?

A. Not, not -- no, not at all.

Q. When you refer there in paragraph 9 to the history of self-harm and suicide attempts, are you referring there obviously to the fact that he had been admitted for the third time in three months on 4 February and also the ligature incident that you referred to on 20 January 2015?

A. Yes, and also the long-term history. I mean --

Q. Yes.

A. The first attempt was way back in 2002.

Q. Yes. On the incident of 20 January, you say in your statement that your brother attempted to hang himself whilst he was an inpatient. We have the Serious

Incident Report, you have referred to it at the end of your statement, and I think it's right, isn't it, that it wasn't recorded on the Datix system, that incident?

A. I believe not, no.

Q. You state in your witness statement at paragraph 9 that your brother told staff he was feeling suicidal on 6 February. Now, you indicated earlier that you couldn't necessarily remember this occasion, so it may be there's nothing further you want to say on it but is there anything you would like it say about whether that was adequately considered as part of any risk assessment process?

A. What did happen at that time, he was a telephone engineer, he was in charge of -- I forget what they called it -- global communications for a big company, a big international company. So his phone was all-important to him, and he would text us more than once a day sometimes, and we visited on an almost daily basis. So there was a lot of communication going backwards and forwards between us. But at that period, around the 6th or the 7th, he texted me and said, "I wish I was dead".

My husband looked at that and said, "That's another level". It was on a completely different level to what he had texted or said in the previous weeks, and so to

my husband that was a big red flag and he got on the phone to the ward to warn them.

Q. I am not asking you to name any clinicians but can you recall whether it was a receptionist, a nurse?

A. I don't know, my husband made the call. So it was somebody on the ward.

Q. To the best of your knowledge, that telephone call hasn't been recorded in documentation you have seen since your brother died?

A. It came out in the inquest that it wasn't recorded.

Q. You have already touched on the failures in observations and how that links to the risk assessment process. But in your statement, you say very clearly that it was crucial for staff to keep a close eye on him from 4 February onwards because, in your view, he was high risk, but also he started that medication on 5 February and then we have the incident on the 6th or 7th --

A. Correct.

Q. -- where your husband reported concerns. You query in your witness statement whether or not your brother was on hourly observations on 12 February and, if so, why was he permitted to leave the ward? The records indicate that he was on Level 1 observations; is that right?

A. Yes, as I understand it.

Q. Were you aware of that at the time, do you know?
A. I think we were aware that there wasn't much in the way of observations going on. I mean, if you visited him, yes, staff were usually in the glass box, halfway down the ward. In fact, one time I wanted to speak to a member of staff, and I had to wait for quite some time outside the glass box before anybody came to hear what I had to say. It felt a little bit like being the naughty girl at school.
Q. Yes, you refer to it in your statement as feeling like a naughty child standing outside the office --
A. Yes.
Q. -- waiting to be spoken to --
A. Yes.
Q. -- is that right?
THE CHAIR: When someone did actually speak to you, were they receptive, were they polite, were they --
A. I think the word I would use is condescending. I had gone in because frequently he would find that his bed had been changed. So if he went out to get tobacco, for example, which you can't get on the ward and you can't get on the hospital site, he would come back and find that his things had all been packed up and his bags were in the office. So one -- this particular time, he rang me at about 5.00 and said, "I don't know where I'm

sleeping".

Now, I think all of us know where we are going to sleep tonight, you know, and, if you are not well, it's not a good thought to think that you don't know where you are going to be sleeping, and I know that his big worry was, because the ward was busy, that he would be transferred to Harlow. There was a unit over at Harlow. Now, if that happened, he knew that our close support would be more difficult and so, of course, that worried him.

So I went into the ward to ask where he was sleeping and the member of staff who responded was condescending and laughed at my concerns and I had to literally explain, "He is not well, he is in a distressed state and he is upset that he doesn't know where he is sleeping tonight".

One time, he had to share a room with somebody else and there was no privacy curtain. Another time he got sent over to the Crystal Centre, which is the unit for older people and, after that experience, he rang me up and said, "I can't wait to get old", and I said, "What on earth do you mean?" He said, "It's lovely over there, the nights are quiet, the food is better, you get a better proper breakfast".

Q. Was that the Ruby Ward over on Crystal Centre?

A. I don't know which ward it was, but I know it was the Crystal Centre. Yes, "I can't wait to get old"; if only.

Q. When you referred to not knowing where he was sleeping after returning from leave, did that happen on more than one occasion or was that just the once?

A. That's the one major one where he got very distressed about it. I know that several times he got back from a leave and his stuff had been packed up and he was in a different room.

Q. Turning then to leave, while we are on this topic. Obviously, you query why your brother was allowed leave on 12 February when he was suffering from severe anxiety and suicidal thoughts.

That period of leave was unsupervised, wasn't it, he didn't have a chaperone?

A. None of the leave was supervised, none of it was.

Q. Were you, as a family, informed of that period of leave before it happened, do you know?

A. No, and I would say that it never got raised in the inquest or at any other point but, if you go into Chelmsford town centre on 12 February, you will find it full of pink hearts and balloons and stuff relating to relationships.

Q. Right.

A. I believe that was what so distressed him that afternoon.
Q. So, obviously, nobody asked for your views then on whether or not he should be permitted to have leave on 12 February --
A. No, no.
Q. -- or indeed, if you would like to accompany him?
A. No, no.
Q. We know from the records that he went to get tobacco. I think there is an indication that he was going to Broomfield Hospital. There wasn't any tobacco in the hospital and, therefore, he went to Chelmsford town centre?
A. I know he went to Chelmsford town centre because of things that happened.
Q. Do you know how long he was away from the ward during that period of leave? You reference the morning.
A. Yes, I don't. No. But, I mean, if you haven't got a car, which he hadn't by then because we'd taken it away from him, it takes a little while to get into Chelmsford from the Linden Centre, and back.
Q. So presumably you didn't know if he had a set time to return and therefore whether he returned on time or what the plan was?
A. No, I don't think there was any arrangement like that

made at all, any time. In fact, one time, I went -- because he texted me asking for something, and I went to the ward and I got greeted at the door by somebody who said, "He's not here", and I said, "He is here, I know he is here because he sent me this text asking me to bring something in for him".

And I had to get extremely firm in order to be let in and what I said was, "Let me in and I'll show you where he is". So in we went, to the main lounge, he was sitting right opposite the door and I said, "That's my brother". He had already been in there for weeks and that member of staff didn't even know who he was.

Q. Again, I am not asking you their name but do you know what their role was, that staff member?

A. No.

Q. Were they a nurse?

A. No, no.

Q. You don't know?

A. No.

Q. Your brother had other periods of leave during that final admission from the 4 February; is that right?

A. From 4 February?

Q. So on 6 February, 8 February and 10 February he had periods of leave, did you -- if you didn't know that, that's --

A. I am not sure about that.
Q. You're not sure. I think, if just if it helps to prompt your memory, I think on 8 February the period of leave was with your husband?
A. Possibly. Yes. Would that have been a Sunday because he came home -- he came to us for Sunday lunch.
Q. Okay.
A. So if that was a Sunday, that was that visit.
Q. Yes.
A. And that was when they had the conversation about being very careful this week.
Q. Yes, because of the medication?
A. Yes.
Q. Yes. Were you aware at the time that your brother was declined leave on 9 February --
A. No.
Q. -- the day after that?
A. No.
Q. No.
A. No, but I wish it had happened more often.
Q. I am going to ask you now about your obvious concerns in relation to how your brother was able to obtain the items that he did in order to ligature.
Are you happy to continue --
A. Yes.

Q. -- with your evidence for the moment?
A. Yes.
Q. You query how he got access to a lighter and how staff didn't notice that he had a lighter. Have you ever been provided with an explanation as to how he came to be in possession of it?
A. He gave us an explanation, which was "They do search to see if you have got a lighter sometimes, but the thing to do is to have a few lighters, if they see you have got three or four, they will take three and leave you one". I know.
Q. So do you know whether he was searched on return to the ward that day?
A. No, I don't know.
Q. You don't know. So you don't know if they confiscated any lighters from him on that occasion --
A. No.
Q. -- or any items?
A. No.
Q. Do you know whether he was permitted to smoke on the ward, for example in a garden?
A. Yes, there was a little garden and that had, as I understand it, a post with a lighter in it. So the idea was that if you were a smoker, which to be honest nearly everybody on the ward was because there was

nothing else to do but go out into that garden and smoke. Yes, so there was a sort of post lighter.

Q. Yes.

A. Hence, there shouldn't be a need to have a pocket lighter.

Q. Yes, and so your understanding, based on what your brother was telling you, is that he should have been searched when he was coming back to the ward?

A. Well, I believe that was --

Q. As you say, he had --

A. -- the policy and that was the point of having a lighter in the garden --

Q. Yes.

A. -- that patients wouldn't have one.

Q. At paragraph 14 of your witness statement, you query how and why he had access to a load-bearing bin and you go on to state that, during the inquest, you believe there was a discussion as to whether or not the bin was regulation compliant and, in fact, it came out that it was 45 centimetres tall and not 30 centimetres tall; is that right?

A. That's correct. It was also incredibly strong. I think you could have stood two 14-stone men on it. But when we were taken into the ward and shown the bathroom, we didn't say anything at the time but all three of us were

shocked to see that bin by the door.

Q. Was that some time after your brother had died --

A. Yes, it was.

Q. -- that you went?

A. Yes, it was.

Q. Do you know, are you talking weeks, months? If you don't know that's absolutely fine.

A. More than a week.

Q. So more than a week later the bin was still there?

A. Yes, yes.

Q. I am going to ask you briefly about your concerns in relation to the Serious Incident Investigation Report that EPUT prepared.

A. Can I just go back to that bin?

Q. Yes.

A. So I believe that bin probably was still there at the time of the inquest in October because, at the inquest in October, the Chief Executive was unaware that that bin was outside of the regulations. In fact, he asserted that the bin in the bathroom was, you know, a regulation one and I didn't say much at the inquest but the one thing I did say was, "Can we have that bin in here?", at which point the whole jury gasped in horror.

Q. So is it right that they did bring the bin --

A. Yes.
Q. -- and they measured it and it was 45 centimetres not 30 centimetres as the Chief Executive believed?
A. Yes, yes, yes.
Q. Just turning to the serious incident investigation report. You state at paragraph 16 of your witness statement that it notes the incident type as a failure to prevent inpatient suicide and you go on to explain that that report states that your brother died on 18 February when, in fact, he died the day before, on 17 February 2015?
A. Yes.
Q. Have you ever been provided with an explanation as to how his incorrect date of death came to be recorded in the Serious Incident Report?
A. Well, I think we are probably all aware that their recordkeeping was poor.
Q. You also received a letter from EPUT after your brother died and you state that that set out changes and improvements that had allegedly been put in place to ensure that nothing similar can occur again, and this is at paragraph 18 of your witness statement. If you would like to have a look at it.
I am not going to go through everything there. But one of those improvements is that the search policy has

been revised. Do you know how the search policy was revised following your brother's death?

A. No.

Q. So you have never been provided with any information as to practically what that means?

A. No, no.

Q. Another improvement is said to be that bathrooms remain unlocked at all times. When your brother ligatured, had he locked the bathroom door, do you know?

A. I believe so. I think what they mean there, when they talk about bathrooms remained unlocked at all times is because there is a policy on wards where they have got patients who are high suicide risks to keep the bathrooms locked, so that patients have to request that the bathroom -- and then because, as I understand it, bathrooms are frequently used and, in fact, had been in his plan always. If anybody had asked him what his plan was, it would have been what happened.

So bathrooms are known to be a risk area and, if you have got high-risk patients on the ward, I think it's usual to keep the bathrooms locked and for patients to ask when they want to use it, whereas that wasn't the case on this ward.

Q. Presumably then, you are suggesting be supervised whilst using, given that they have had to ask for permission?

A. Yes, and they are constructed so that you can have the door open but draw a curtain across behind where the door is so that a member of staff can stand outside and have some understanding of what have's going on in the bathroom.

Q. You set out in your witness statement on page 6, paragraphs 19 all the way through to 27, various things that you would like to ask the Inquiry to investigate, mainly whether the changes that EPUT allege were put in place after your brother's death were actually implemented. Have you ever received any updates from EPUT as to whether the actions stated within that letter --

A. No.

Q. -- have actually been implemented?

A. No, no.

Q. We have touched briefly on the inquest into your brother's death but I just have a couple of questions for you in relation to that. You state in your witness statement that it was held on 27 October 2015 and the coroner concluded that, as a result of insufficient communication, adequate precautions were not taken to minimise the risk to your brother?

A. Yes.

Q. You further state in your witness statement at

paragraph 39 that it was evident to you that the CEO was not aware that the bin in the bathroom was not in accordance with regulation, and you have just described in fact the process by which you asked for that bin to be brought to the inquest --

A. Yes.

Q. -- for it to be made clear.

You also state that he, the CEO, did nothing to put in alarmed doors, which had already been recommended.

Can I just check, do you mean that alarm doors had been recommended prior to your brother's death --

A. Yes, I believe they were.

Q. -- or --

A. I believe there was a death about six months beforehand and that was a recommendation that came out of that.

Q. Are you saying it was acknowledged at the inquest that that was a failure that those measures hadn't been put in place?

A. I don't remember any acknowledgement but, I mean, clearly it was a failure.

Q. To the best of your knowledge, was there an alarm in place in relation to the door that your brother used to ligature?

A. No, there wasn't. No, there wasn't.

Q. Is it right that there was a jury at the inquest --

A. Yes.
Q. -- or was it just the coroner? A jury.
You have touched on this earlier. You refer to staff saying, "We never thought he would do that".
A. Right.
Q. Again, I am not asking you to name individual clinicians --
A. I couldn't.
Q. -- but do you know was it nursing staff saying that, consultant psychiatrists?
A. Yes, it was nursing staff saying it.
Q. Nursing staff?
A. Yes.
Q. So the impression that you gleaned from the inquest was that the nursing staff thought that your brother would never --
A. Yes.
Q. -- follow through with his intentions?
A. And I think that's the lack of communication that the coroner referred to, is that there was no communication between, perhaps, medical staff, some of whom but I don't believe all, knew what his condition really was and the nursing staff, who frankly didn't have a clue.
Q. I am going to ask you some questions about the ward environment. You have touched upon some concerns as we

have gone through, so I won't repeat those, but you state in your witness statement that there was no noticeable therapeutic activity at all. Is that based on what you personally observed and what your brother was telling you?

A. Yes. There was -- he went to one session, which was some sort of movement class and he told us about this. So he went to this session and whoever was leading the session clearly also had no idea how ill he was, and picked on him to start the movements.

So I think it's this thing where, you know, one person makes a certain movement, everybody else in the room follows it, I am not quite sure what the therapeutic use of that was. And he came and told us about it and he laughed and he said, "She picked on me", and we said, "Okay, what happened?" He said, "I just burst into tears and went out".

Q. Yes. Understood. You also make reference to an occasion where your brother did a jigsaw as a form of therapy and then --

A. Yes.

Q. -- a staff member completed it while he took a break?

A. From the minute was admitted, he started asking me for jigsaws and I took them in on a regular basis when he -- and this was one of his strategies. I mean, he had

myriad strategies for coping with what his mind was doing to him and one of them was get lost in a jigsaw. And, yes, I mean, that day he rang up crying, he had left it partway done and a member of staff had come along and finished it for him, which was not the point.

Q. No, and so you found out about that incident because he telephoned you --

A. Yes, he told us, yes.

Q. -- and informed you.

You also state in your witness statement that there was a gym on the ward but no staff, so it couldn't be used, and you've alluded to the fact that actually your brother found running quite a useful form of therapy?

A. Yes, yes. It was a way to wear himself out and get to sleep. I never saw a gym, didn't know about the gym but was told about this later. I don't know even if it's true. But if it is true, and it wasn't in operation because of lack of staff, that would fit with everything else because the whole impression was we are not quite coping here and, certainly, from our observation and, in particular my husband's, the level of staffing, training and knowledge and understanding was way too low. If he came home once and said, "Where is their sense of clinical excellence?", he did it a lot of times.

Q. Sticking on the topic of staff for a moment. At

paragraph 32 of your witness statement, you say that ward staff were hostile and you have provided an example of another inpatient taking your brother's phone and the staff being uncaring and uninterested, and you explain how important it was to him to have his phone to be able to communicate with you?

A. Yes.

Q. Did you personally witness interactions of that nature or was that impression based on things that your brother was telling you over the phone, or in person?

A. Yes, we -- my husband and myself, we both felt that staff were unwelcoming, unwilling to engage with us, yes, hostile. And, I mean, it is sad to think about it now but I think that probably meant that we avoided contact and certainly, you know, there were visits where our visit, our interaction with him were interrupted by other patients who couldn't, couldn't understand that, that we needed peace and, you know, staff did nothing about that.

To be honest, my whole -- of all the times I visited, my whole recollection is that the staff were in the glass box, in the office, and that really puzzled me because I have nursed and I know that, although in ancient history when I was nursing we had a glass box, it's not the thing anymore on wards in hospitals. There

is a desk in the middle of the ward and, you know, things are managed openly and staff are out and about with patients, that wasn't the case on the Linden Centre.

Q. So no one was milling around when you visited, it was always a case that, if you wanted to speak to a member of staff you would have to go to that central hub, the glass box?

A. Yes, absolutely, absolutely.

Q. Obviously, it is a glass box, so you can see into it. What were the staff doing, as far as you could see when you went to --

A. As far as I could see, sitting around chatting and there was a big box of sweeties there, always, Quality Street, I think.

Q. You make reference in your witness statement to staff not stopping troublesome patients harassing --

A. Yes.

Q. -- your brother --

A. Yes.

Q. -- while you were present. Is that what you were just referring to --

A. Yes, yes.

Q. -- where patients did not realise you needed space?

A. Yes, yes, and that no matter how often they chatted him

up, he wasn't going to be their boyfriend.

Q. At paragraph 35 of your witness statement, you state that, on one occasion staff, saw your brother attempting to hang himself outside the office and they interpreted that as attention-seeking when, in fact, it was a cry for help. Was that the 20 January 2015 incident?

A. Yes, I believe so.

Q. What brings you to the conclusion that they decided that was attention-seeking, was that something that came out at the inquest, did you say?

A. I think it did, yes. I was quite shocked to hear that phrase used.

Q. Do you know now what your brother's view was in relation to that incident and how staff treated him after it?

A. No.

Q. No. Finally, on staff, at paragraph 39, you state that inappropriate staff were employed to work at EPUT presumably because they were cheap to hire. Can you provide any examples of staff, who you say it was inappropriate to hire again. I am not asking you names.

A. Right. So there was a medical doctor, who I looked up afterwards and he was trained as a GP, who was acting as consultant psychiatrist on the ward. And he was the one who had the most dealings with [W4] -- with him -- sorry, oops.

MS LEA: That's okay, we will just pause for one moment.

Chair, we will just need to remind everybody once again that there is a restriction order in place in relation to the name of the deceased and therefore nobody is permitted to publish the name.

THE CHAIR: I confirm that I have made that restriction order.

MS LEA: Thank you, Chair.

Mrs Carden we have been going for about an hour. We are now going to turn to your recommendations for change. I have got about 15 minutes left with you.

I am completely in your hands as to whether you would like me to go through your recommendations for change now?

A. Yes.

Q. Yes, or the other option is to have a break for lunch of an hour and come back?

A. Yes.

Q. You are happy to continue?

A. Yes.

Q. So, as I said, I am going to ask you about your recommendations for change. What I am going to do is ask for them to be put up on the screen, so the television screen in front of you will show them as well. I think we have been through, actually, most of

them, as we have gone through, but what I want to do is provide you with a final opportunity to say anything additional that you would like to --

A. Okay.

Q. -- in relation to those recommendations.

Amanda, please can we put up paragraph 40 on page 10 of Mrs Carden's witness statement.

Mrs Carden, you say there:

"Every ward must have plenty of caring staff. Staff shortage impacts the care given to patients."

Would you like to say anything further about staff shortages in relation to your brother's care?

A. I -- it's not just about shortage, but it's about well-trained staff who understand. I mean, I'm going back to ancient history again, but when I was nursing, sometimes there would be a situation where a nurse would say to a doctor, "This patient is displaying this symptom". You know, in other words, gently querying a diagnosis or a -- or a pattern of treatment. There was no sense in which that was ever going to happen on this ward because staff just swallowed the "attention seeking/anxious person" summary of him and -- and none of them properly got to listen to his life situation, to what was going on in his world and the distressing time that he was going through.

So although there was some "caring" it was -- it was, in my mind, it was done by people of low training; healthcare assistants rather than qualified psychiatric nurses and with the best will in the world you can't give good care to somebody without proper training.

Q. Yes.

A. And the other thing is that I think the staff on the ward felt that they were short-staffed.

Q. Mm-hm.

A. And that was why they were so ready to let people have leave who weren't sectioned.

Q. And you mentioned right at the outset of your evidence that you felt there was a shortage of beds. You referenced a time where your brother took two patients home with him. So --

A. It seemed that way, yes.

Q. So the combination --

A. And the -- and the other thing is the sending him over to the Crystal Centre.

Q. Yes.

A. That would indicate there was something of an issue.

Q. If we could please have the next paragraph, Amanda, paragraph 41. You state:

"The wards should be small and there should be no office for staff to hide in. They should be interested

in patient lives and respect input from family members."

You have explained your concerns in relation to having to wait outside the glass office. You describe it like being a naughty schoolchild.

Is there anything further you would like to say about either staff hiding in the office or not being interested in patient lives or respecting your input as a family?

A. Well, we had conversations, short conversations with several members of staff about my brother, and it was clear that they didn't know his life circumstances. They didn't know what was going on in his life at the time. I do not understand how you can help somebody with a mental health condition if you don't know what struggles they are having in the world outside the ward.

Q. Thank you.

A. And, you know, there are some parts of that that the patient may want to keep private, shall we say, or you could, say, cover up.

Q. Yes.

A. But the family members will be able to give information on that.

Q. Yes.

A. And I think there was a real lack of respect for family members. And of course in our case, with my husband

being so qualified in this area, that was very, very silly not to use his expertise, not to understand his level of understanding of the conditions.

Q. And so did you feel that you didn't have that opportunity to put forward your views but also when you did they just weren't listened to?

A. Definitely. Definitely. On one admission when I went to the ward with him to be readmitted there was the kind of "interview", "admission interview", and there were things that I would have liked to tell the staff but not in front of the patient.

Q. Yes.

A. That was never an opportunity.

Q. Thank you. Could we have the next paragraph please, Amanda, paragraph 42. You state there, Mrs Carden:

"The staff must ensure that the environment is kept safe for people depending on what is dangerous for each patient. For example, what can be problematic for one patient may not be for others. Understanding each and every patient properly is crucial."

Does that feed into what you have just been saying --

A. Yes.

Q. -- about getting all the information --

A. Yes.

Q. -- available from all sources?
A. Yes. You can't help somebody with mental health problems without knowing them or spending time with them and, if you are constantly letting them either be discharged or have leave, it's never going to happen.

I mean, you know, it completely explains the situation where he'd been in there for weeks and the member of staff didn't know what he looked like or who he was, and was absolutely convinced in telling me he wasn't on the ward.

Q. Thank you.

Amanda, could we have the next paragraph, please, paragraph 43. You state there, Mrs Carden:

"Staff must give medication as prescribed and be aware of critical information like medication changes, how this affects inpatients, bereavement, relationship problems."

Again, that feeds into the discussion we have just been having but also we refer back to the fact that the side-effects of the medication, that increased risk for 14 days, weren't taken into consideration in your view; is that right?

A. Yes, absolutely.

Q. Thank you. Finally, paragraph 44, please. You state there:

"Good nutrition, quiet nights, therapeutic activities are [all] very important for an inpatient to be on the road to recovery."

In fact, you provided evidence earlier that your brother said that on Ruby Ward, in the Crystal Centre, he actually found that those things were in place and his experience --

A. "I've got a breakfast!"

Q. -- was much improved?

A. "Not a piece of toast!"

Q. Yes.

A. I mean, we all know that good nutrition, a good night's sleep is kind of crucial for good health, generally, as well as mentally.

MS LEA: Yes. Thank you. Please can we take down the statement, Amanda.

Mrs Carden, that concludes my questions for the moment.

Chair, do you have any further questions?

THE CHAIR: No, I don't, thank you very much, Ms Lea.

MS LEA: Thank you.

Mrs Carden, what we are going to do we are going to take a 10-minute break to see if there are any further questions for you. If there aren't any further questions, we will release you and let you go and that

concludes your evidence.

A. Thank you.

THE CHAIR: Could I take this opportunity to say thank you very much for your evidence, very clearly given, and we really appreciate it.

A. Thank you.

THE CHAIR: Thank you.

MS LEA: Chair, for those watching, the live feed, if we don't return after the 10-minute break, we will be returning at 2.30 with the witness who we are hearing from this afternoon, Patrick Brennan.

THE CHAIR: Thank you. 2.30, unless there are further questions.

(1.23 pm)

(A short break)

(1.40 pm)

MS LEA: Thank you. Thank you, Chair.

Chair, Mrs Carden has returned to the witness box, for which I am grateful. There are two points that she, in fact, herself has raised that she would like to mention. The first is in relation to the term "informal", in relation to admission, as opposed to sectioned or not sectioned.

Mrs Carden, what would you like to say about that?

A. I think it gives staff the wrong impression. If you are

sectioned, they understand that you are seriously ill. But my brother wasn't sectioned. He agreed to go in, as we discussed earlier. And I know that the word "informal" is linked to that kind of patient, they're an informal patient. The word "informal" gives a completely false impression of how ill they might be.

THE CHAIR: Yes.

A. Even though they have -- you know, they have agreed to go in, it doesn't mean that they are less ill.

MS LEA: Yes. Thank you. Mrs Carden, the second thing you would like to raise is an incident of unprofessional staff behaviour.

Would you like to tell us a little more about that?

A. We were shocked to hear from him that, on the ward, someone was going amongst the staff making a collection before Christmas for their Christmas party and he told us he was -- he was a really generous, kind and caring person, and he told us, "I've contributed". So they allowed him to make a contribution to the staff Christmas party, which struck us as a completely unprofessional and incorrect thing to have allowed to happen.

They had no idea of his financial situation, whether he could afford that or not. He was a mental health patient. You don't take money from mental health

patients, unless you know that it's for a good purpose, for a good reason and it was -- it just, you know, staggered us that that could happen on a place where they were supposed to be looking after him. And, you know, to take money from somebody who you know is ill has always got to be wrong, whether you are a professional or not.

MS LEA: Thank you.

Chair, that concludes Mrs Carden's evidence.

We will break now for an hour until 2.30 pm, where we will resume with our witness for the afternoon Patrick Brennan.

THE CHAIR: A little less than an hour.

MS LEA: A little less.

THE CHAIR: Three quarters of an hour, 2.30 pm.

(1.43 pm)

(The short adjournment)

(2.40 pm)

THE CHAIR: Patrick Brennan. Please.

PATRICK BRENNAN (sworn)

Questioned by MS PUCKS

MS PUCKS: Thank you, could I ask you to please state your full name?

A. Patrick James Brennan.

Q. You are the father of Liam Patrick Brennan?

A. Yes, I am.
Q. Is it right that Liam died on Tuesday, 14 August 2012, four days after he turned 29 years old?
A. Yes.
Q. You are here to give evidence about the circumstances of his care and treatment and his death; is that right?
A. Yes, I am, yes.
Q. You have indicated that you would be happy for me to refer to your son as Liam throughout these questions and to yourself as Patrick?
A. Yes, of course.
Q. Thank you. Now, by way of background, the Inquiry sent you what we term a Rule 9 request, requesting your evidence for this Inquiry; is that right?
A. Yes.
Q. In response to that request, you provided a witness statement?
A. Yes, I did.
Q. Yes, and, Chair, as you know, a redacted version of this witness statement will be published on the website. You also gave a commemorative statement to the Inquiry, which you read out in September of last year?
A. Yes.
Q. May I say that we are incredibly grateful to you for both of those accounts.

A. Okay.
Q. Do you have a copy of your witness statement in front of you?
A. Yes, I do, yes.
Q. Right at the top, it has your name on it?
A. Yes.
Q. Yes, and the date, being 4 June 2025?
A. Yes.
Q. Is it right that on page 25, the last page of your statement, you have signed the statement?
A. I did sign it, yes.
Q. Okay. Have you had an opportunity to review this statement recently?
A. Yes, I have.
Q. Are you happy that the statement is accurate?
A. I am, yes.
Q. Is it right that you would like this statement to be considered your evidence to the Inquiry?
A. Yes, please.
Q. Thank you. Now, as you know today, I will be asking you some questions about this witness statement. We will not be going through it line by line but we will be drawing on the themes that are set out therein, but you can be assured that the Chair and the Inquiry team have read and will consider everything that is in this

statement very carefully.

A. Okay, thank you.

Q. I remind you that you will not be asked to name any individual staff members due to the restriction order in place?

A. Of course, yes.

Q. Thank you. Now, we will be stretching your evidence in three parts today: first, we will go through a timeline of Liam's involvement with the Essex mental health services, specifically NEPT; second, I will ask you questions about your concerns relating to his care and treatment and how you, as his father, were treated following his death; and third and finally, I will ask you questions about your recommendations to the Chair in light of your experience?

A. Sure.

Q. I will start, therefore, by going through a timeline of his involvement and these are set out at paragraph 4 to 28 of your witness statement, in case that assists. As far as his early background is concerned, you start your statement by telling us that, like many people, Liam found his teenage years to be quite difficult; is that right?

A. That is true, yes.

Q. Especially from the age of 14 onwards. Where was he

based at this time?
A. He lived in Barnet, which was the family home.
Q. He had his first overdose at the age of 17, which resulted to him going to A&E and then a subsequent referral to The Priory in Barnet; is that right?
A. That's correct.
Q. Was that A&E also in Barnet?
A. Yes, it was, Barnet General.
Q. Was this his first interaction with any mental health service?
A. As far as I am aware, yes.
Q. Is it your understanding that in this consultation he was diagnosed with attention deficit hyperactivity disorder?
A. At The Priory, yes.
Q. At the Priory. Is it right that, during this time period, you were, in fact, in Ireland?
A. Yes, I was. I was working on a three-year secondment at that time.
Q. I understand. He was 17 at the time, so that would have been in around the year 2000?
A. Correct, yes.
Q. Other than this episode at the age of 17, is it right that he had no other engagement with mental health services prior to January 2011?

A. Not to my knowledge, no.
Q. You describe him in your statement as being a good place emotionally throughout that time period?
A. Yes, I mean, he was working for a while in Wales and my wife and I went to visit him there and he was enjoying working there, and he seemed to have a full life there, and then he decided he wanted to come back to London. I brought him back to London, we drove back, and he had a job working in a gastropub in Islington, I think, in the kitchens there, and then he later on had a similar job in Hertfordshire, Ayot Green.
Q. A similar job in working as a chef; is that right?
A. Working as a chef, yes.
Q. The way that you describe it in your statement is that he was generally in a good place emotionally, in that time period, but is it right that there were periods where he just felt adrift, is the way that you phrased it, and that he just couldn't quite get his arms around it all?
A. I think he was always one of those people who seemed to me to be -- to find true or profound happiness quite difficult to achieve or feel all of the time. He was not materialistic at all, quite the opposite, but he was just one of these people who, frankly, just wanted to be happy and a lot of the time I think he was. But there

were occasions when he didn't feel like that and it seemed to really get him down.

THE CHAIR: Did he experience that as a child before the incident with the overdose?

A. I think perhaps during his teenage years I would suggest that was the case. But not necessarily during his primary school time, although he was quite strong willed and so, therefore, he was very much his own person and he didn't necessarily go with the crowd, as it were, at primary school but, at the same time, he wasn't what you would regard as a loner, for example.

THE CHAIR: Thank you.

MS PUCKS: Thank you. Is it your evidence that in 2011 to 2012, that time period you have referred to, that he essentially went through a cycle of drug and alcohol misuse, A&E admission, mental health referral, inpatient stay, discharge, and repeat.

A. Yes, it was very much an admission/discharge/repeat process, borne out even more so once I actually got a copy of the hospital notes. I was obviously aware that he was going into hospital on these occasions but, when one looks at the hospital notes, it's very significant and it's a real obvious trend that he was admitted, then usually, within a pretty short period, he was then discharged but then he would find himself

needing to go back again.
Q. Thank you. In terms of how I propose to structure the timeline going forward, if I have understood it correctly, there are, in fact, nine cycles --
A. Yes.
Q. -- that he went through and I propose to go through those nine cycles now?
A. Okay.
Q. The first cycle started in January 2011. He was 27 years old; is that right?
A. Yes, he would have been, yes.
Q. On that occasion, he stabbed himself in the leg whilst he was drunk, following which he went to A&E at Princess Alexandra Hospital, and is it right that he was referred to psychiatric liaison but, despite that referral, no psychiatric assessment in fact was undertaken and he was discharged?
A. That's correct.
Q. So that was in January 2011. The second cycle starts in June 2011, and is it right that this one starts with his aunt being worried about his alcohol misuse, low mood and occasional thoughts of suicide and, therefore, took him to A&E?
A. That's correct, yes.
Q. At this stage, he was in fact assessed by a psychiatric

liaison team and received a diagnosis of mental and behavioural disorder due to the use of alcohol, emotionally unstable personality disorder?

A. Correct, yes.

Q. Was this diagnosis explained to you at the time?

A. No, it wasn't.

Q. Do you know whether he was offered any home treatment following this diagnosis?

A. I am not aware that he was offered any such treatment.

Q. In fact, is it right that he self-referred himself to the Trust's alcohol and drugs advisory service and was appointed a counsellor with whom he had sessions intermittently?

A. Yes, he did.

Q. Did you think that that had a positive impact on him?

A. Yes. I think Liam seemed to strike up a good relationship with the individual who was looking after him and I am aware that his mum valued those sessions as well because they seemed to have a positive impact.

Q. That's the second cycle. The third cycle starts on 10 August 2011, where he attended an outpatient clinic appointment at Princess Alexandra Hospital with a psychiatrist, who then, as I understand it, became Liam's responsible clinician; is that right?

A. Correct.

Q. Do you know what precipitated this attendance or was it simply an appointment?
A. I must admit, I don't know.
Q. Is it right that diagnosis then changed to mental and behavioural disorder due to multiple drug use and use of other psychoactive substances, and this time it was mild moderate depressive disorder without somatic symptoms?
A. That's correct.
Q. Again, did you understand what this diagnosis meant at the time?
A. I wasn't aware of the diagnosis at the time.
Q. I understand. Do you know whether he received any treatment following this appointment?
A. I don't know.
Q. The fourth cycle starts in November 2011 and results in his first inpatient stay.
A. Yes.
Q. In November 2011, following what you believe was a heroin overdose, is it right Liam was found unconscious in the street, taken to A&E and then informally admitted to that Chelmer Ward at the Derwent Centre in Harlow.
A. That's correct.
Q. Was that his first admission?
A. It was, yes.

Q. He was admitted on 2 November, discharged almost two weeks later on 16 November; is that right?
A. Yes, that is right.
Q. Again, a slightly different diagnosis. Is it right that it changed to mental and behavioural disorder due to polysubstance and alcohol misuse, emotionally unstable personality disorder, borderline type?
A. That's correct.
Q. Back to a personality disorder diagnosis?
A. Yes.
Q. Thank you. Now the fifth cycle starts on 10 December and is it right that, following what you understand to be self-harm, he was once again taken to A&E and then admitted to the Chelmer Ward?
A. That's correct.
Q. Do you know if he received the same diagnosis this time?
A. I am not aware, no.
Q. This time, his admission was slightly longer; is that right?
A. That's right.
Q. It was 10 December to 17 January, so a total of almost five and a half weeks?
A. That's correct, yes.
Q. Thank you. The sixth cycle started on 27 February when his mother contacted the community mental health team

and expressed her concerns and is it right that he was then admitted to the Derwent Centre again?

A. Yes, he was, yes.

Q. This time, it was Stort Ward; is that right?

A. Yes.

Q. You set out in your statement that on 13 March you in fact attended a meeting with Liam and his psychiatrist?

A. Yes, I did.

Q. As you know, we will not be naming any staff members during the course of this hearing, so I will simply refer to them as Liam's psychiatrist. Is it right that his psychiatrist's advice was that Liam remain an inpatient?

A. It was, yes.

Q. But Liam was concerned about the treatment he was receiving and did not think that the ward environment was doing him any good and he felt well enough to leave; is that right?

A. Similar to previous occasions when he received hospital treatment, he had reached a stage where he felt he was better off outside, rather than in the ward. From a clinical perspective, I wasn't able to say whether that was a good idea or not, other than, if my son felt that it wasn't doing him any good being in the hospital, then I helped him leave the hospital that day.

Q. Thank you. So he, in fact, discharged himself --
A. He did.
Q. -- on that occasion?
A. Yes.
Q. He was next admitted in April of that year, is that right, on 7 April --
A. Yes.
Q. -- following an overdose. Is it right that, following his overdose, he in fact tried to contact the Trust's crisis line but the call went to voicemail?
A. Yes, it did and Liam's mum, upon being told this by Liam, tried to contact the crisis line herself, only to receive the same voicemail message --
Q. Yes.
A. -- which seemed to defeat the purpose of it being a crisis line.
Q. Yes. In fact, his mother called an ambulance?
A. To take him to A&E, yes.
Q. Yes, and following that, he was once again admitted to Chelmer Ward; is that right?
A. Yes.
Q. Shortly thereafter -- so that took place on 7 April. On 10 April, Liam's mother attended a care review meeting with Liam and his psychiatrist?
A. Yes.

Q. Yes, and at this meeting, is that when they were told that a psychologist would not be available for a year?
A. That's correct.
Q. Is it right that this prompted both Liam and his mother separately to submit complaints?
A. Yes, so Liam's mum sent an email to the hospital drawing their attention to Liam's previous suicide attempts and that having to wait a year for help just wasn't acceptable --
Q. Mm-hm.
A. -- and expressing the fear that he might be successful in one of these attempts before help was going to be received. As you say, Liam, at the same time, submitted his own note of complaint --
Q. Yes.
A. -- at which he expressed dissatisfaction with the treatment he had received up till then and, just as importantly, the support he was getting in the community.
Q. Yes.
A. And, therefore, wanting the support quicker than in 12 months' time.
Q. Yes. In fact, that complaint was received and, following this complaint, two things happened, is that right, one an appointment was scheduled for Liam to have

with a clinical psychologist?
A. Yes, that took place on 23 April.
Q. That's right.
A. So having made the complaint it does seem that that was somehow fast-tracked, which was good news from our family's point of view, but why did it need to take a complaint to achieve it?
Q. Yes.
A. The following day, 24 April, there was a meeting which involved Liam, his mum, myself, the operation -- the operations -- operational services director, Liam's consultant, that you have already just mentioned, and also a "making experiences count" manager.
Q. Yes. So two managers and the psychiatrist?
A. Yes.
Q. He, in fact, stayed in Chelmer Ward for some time until 29 May; is that right?
A. That's correct, yes.
Q. Is it right that, following the Trust meeting that you just set out, the one on 24 April, Liam was in fact offered accommodation at NACRO, which is where he then went to stay?
A. Yes, he was. At that meeting, I mean, we expressed -- and perhaps we will come on to this later, I don't know --

Q. Yes.
A. -- but just to highlight now that we expressed our lack of confidence in the diagnoses to date, the treatment plan, if there was one, that didn't appear to work, the cycle of admission and discharge that we have already mentioned, and the lack of support in the community.
Q. Yes.
A. And I recall saying at that meeting that, if this didn't turn out well, we all had to be able to look at ourselves and know that we have done our best, which was difficult to say in front of my son, I am sure it was even more difficult to hear from his dad, but it just showed the level of desperation we had collectively from some help from the professionals, not least because, at that meeting, the central theme of advice that came out from the professionals was that Liam had to want to get better, to which I remember saying, "Don't you think we might have said that to him many, many times", and all that did was undermine our confidence even further that this was a clinical team that either understood Liam or had the first idea on how to actually help him.
THE CHAIR: What did they mean by "Liam had to want to get better"? Did they explain what wanting to get better and what that might mean he needed to do?
A. Sure. I don't recall them actually spelling it out.

What I took it to mean then and probably still take it to mean is that, if he didn't resort to alcohol and/or substance abuse, that that would be a help and that if perhaps he reacted more positively to some of the activities that were suggested for him when he was in the Chelmer Ward, that might help, too and that perhaps his, Liam's, mood was such that he somehow had to try to lift himself out of this dark hole that he found himself in occasionally.

But I think most of us on the outside of that conversation could probably appreciate that an individual who might find themselves in those circumstances needs help to do that. Simply being told to do it isn't going to achieve it.

THE CHAIR: So can I ask two supplementary questions?

A. Of course.

THE CHAIR: Were they also offering or suggesting that they would give him that help?

A. Well, I think they were hopeful that the psychologist support, which had only started the previous day, might be the start of a different workstream of help, if I can phrase it if in that way.

THE CHAIR: So they weren't entirely offering -- placing the onus on Liam?

A. I think -- I think when you are in a meeting like that,

I think that when you feel -- and I can only speak for myself here, I am not speaking for Liam at this juncture -- but when you feel that the professionals haven't got a grip of what's actually wrong with him, it then means, well, what are you actually going to do for him? And I didn't get the impression they actually knew what to do.

THE CHAIR: I understand.

A. And so, therefore, what comes across most loudly and clearly is this emphasis that he had to -- Liam that is -- he had to "want to get better", using their words, and that that would take us a significant step forwards, and I do agree, it would do if he could do that.

THE CHAIR: What was Liam's response to that? Was there a part of Liam that accepted that or was Liam left as bereft as you sound as though you were?

A. I know that Liam just didn't have confidence in the team. I think his -- he just didn't have a relationship with the consultant psychiatrist from the hospital and that was clear from my meeting on 13 March, never mind 24 April, and indeed on 24 April, to my memory, the consultant psychiatrist said very little. It was principally the Operational Services Director who did most of the talking on behalf of the Trust.

And I think that, in many ways, it just -- it left

Liam no further forward nor behind than he was before. And I remember he, Liam, his mum and I talking outside the building after the meeting and I think we were all at a loss as to actually what to say to one another. It was such a dispiriting meeting that we were left in -- or certainly I was left thinking, "I am not sure what to do next".

I am not saying that nothing came of that meeting because what had come at least out of setting up the meeting were the psychologist meetings which Liam did attend on 23 April and continued to attend afterwards, and the accommodation provided by or organised by NACRO materialised, which was a -- on the face of it a positive step forward also.

So I think that, despite the fact that the meeting left us at an impasse, something came of it. But perhaps, as we will go on to find, some other elements of the support did not change and I think, key to that support, both from our point of view and actually from the Trust's point of view, because this was pointed out several times by them, was that it was for the community psychiatric nurse, who was allocated to Liam's case, to pull all the pieces of the treatment jigsaw together.

I have examples which we will come to later of meetings he didn't attend, Liam certainly laboured the

point on a number of occasions that that guy didn't attend meetings that were set up for Liam and that, of course, completely undermined Liam's confidence in the support he was getting. But that person, for reasons that were not explained on the day, didn't attend this meeting either. His apologies were given at the meeting but, for such a critical meeting -- because for us that's a real pivotal moment -- he wasn't there, and I think we probably regarded that as -- at the time, as typical.

THE CHAIR: Thank you.

MS PUCKS: Thank you. We have got two more cycles to go through, if I may before we then turn to your concerns.

A. Okay.

Q. I am grateful. The 24 April meeting was in the middle of the seventh cycle and he was discharged on 29 May but is it right that he was then once again admitted on 24 June to Chelmer Ward, and do you recall what precipitated that admission?

A. I don't, no.

Q. Is it right that he was then discharged once again just under two weeks later?

A. That's right, yes.

Q. Thank you. The ninth cycle starts --

A. If I may go back to that though?

Q. Of course.
A. Again, there was a diagnosis given that, at that time, according to the hospital records, that is slightly different to the ones that were outlined before and this time it talked about emotionally unstable personality disorder, borderline type.
Q. That's right.
A. And I don't know if it's right to touch on the fact now that, when I met with Liam and the consultant psychiatrist on 13 March, Liam warned me, going into that meeting, he said, "You are going to see diagnosis by Google here".
Q. What did he mean by that?
A. Well, he told me that I would somehow be shown a Google definition of the diagnosis that had been formulated for Liam and I must admit I said to Liam at the time, "Look, don't be so cynical", you know, trying to play up the fact that "These guys are trying to help you".

But when I went into the room for the meeting, there was a screen up and there was borderline personality disorder definition as per Google up on the screen and, although we didn't discuss in depth what that actually meant, it was used as a way of telling me that is what we think Liam's diagnosis is.
Q. So was that, in fact, used for your benefit, to tell you

what the diagnosis was?

A. That -- yes, yes.

Q. The ninth cycle starts on 2 August. Is it right that he had a confrontation with a new resident at the NACRO accommodation, following which he was briefly sectioned for his own safety?

A. Yes.

Q. Yes. Did he, in fact, go to Chelmer Ward again on that occasion?

A. No. I don't think he did.

Q. No.

A. I think he was taken to somewhere near Colchester.

Q. Right.

A. But I can't remember offhand the name of the unit.

Q. Thank you. On 3 August, is it right that the NACRO team tried to contact Liam's community psychiatric nurse but were unable to get through?

A. That's correct.

Q. Then on 10 August, it was Liam's birthday, and you understood he, in fact, spent a really good day with his girlfriend?

A. Yes.

Q. Then on 13 August, the NACRO team once again tried to contact Liam's CPN because she was concerned about his mental state --

A. Yes.
Q. -- and that again was unsuccessful?
A. Correct.
Q. Is it right that his CPN was, in fact, off sick?
A. That's correct.
Q. A message was left for him to call back as soon as possible. It was written in the message book?
A. Yes, my understanding is that the call was made at about 4.15 that afternoon. As you say, the CPN wasn't available due to sickness, and so the process was that any such call would be recorded in their message book --
Q. Yes.
A. -- and that someone would return that call, although clearly it didn't happen that day.
Q. Yes. On 14 August, Liam was tragically found dead at his NACRO accommodation --
A. That's correct.
Q. -- having taken an overdose of prescription and non-prescription drugs?
A. Yes.
Q. Is that right? How were you informed of his death?
A. I was at home and my wife brought out the phone to me and said Elaine, Liam's mum, was on the phone. So I took -- obviously took the call, and she said to me, "Liam's died", and I suppose to kind of buy time to

process that, I said, "How do you know?" Because it was just a bolt, I could hardly believe it, and she said that there are two policemen in my sitting room and they have just told me.

And those policemen had called at the house, and I obviously found this out later and she -- Liam's mum hadn't come home from work yet, so my youngest son had to sit with them but they wouldn't tell him why they were there and it was only then when Liam's mum came home, that they told her what had happened to Liam, and then she rang me.

Q. Thank you. That took some time but I am grateful to you for confirming that background. It's important to ensure we understand the background to then understand the concerns that you are raising with this Inquiry, so I am very grateful to you.

I would like to now move on to those concerns, and these are grounded in six overarching themes, although some might take a little bit longer than others and, just so that you know where we are going, I propose to just set them out to you and then we will go through them one by one?

A. Okay.

Q. So the first one is Liam's lack of confidence in the profession; the second is the ward environment and

whether it is conducive to recovery; the third is how care management plans are developed and followed through; the fourth concerns his treatment, both his prescriptions and also psychological treatment in the community --

A. Yes.

Q. -- the fifth is in relation to these cycles of self-harm/admission/discharge, without a real grasp of understanding the underlying difficulties --

A. Yes.

Q. -- I believe you called this the firefighting approach --

A. Yes.

Q. -- and number 6 relates to post-death communication --

A. Okay.

Q. -- so both with the Trust and in relation to the inquest.

So if I can take those in turn. The first is in relation to Liam's lack of confidence in the profession. You speak about the fact that he received different diagnoses over the 2011 to 2012 period and, within that, you refer to a lack of a clear diagnosis and resulting uncertainty and also a lack of confidence that this lack of clear diagnosis installed in Liam and in yourself. I wonder if you could tell us a little bit more about

that?

A. When you are going through the cycles, you set out what each of the diagnoses were. Now, I have confirmed to you that I wasn't necessarily aware of them afterwards -- until afterwards. But even on the diagnoses that had been communicated to me when I attended the meeting alongside Liam in March 2012, although that diagnosis was up on the board, there was little by way of explanation on the part of the consultant that explained so what that actually meant, both in terms of what did it mean that -- how did Liam's behaviour lead to that diagnosis being made and, equally, what did that mean for his ongoing treatment as a result of that?

I was also aware that -- I mean, Liam was a bright guy, I mean, like, he would go through periods of self-analyses to try to work out for himself what was wrong and he had put forward the view that, whether or not -- given what he knew about himself and what he knew for example about Asperger's, from the point of view of his own research, there are a number of elements that he thought aligned in that way.

He actually raised it with the hospital because I've seen it in the hospital notes since. But there was nothing in the hospital notes that said, "and we have

rejected that because of X, Y and Z", "or we have explained that that isn't an accurate diagnosis for whatever reason".

I think that led Liam to feel a lack of confidence in both what was being said to him and the treatment plan that was therefore laid out as a result of that and, if he didn't feel confident in it, how were we, as members of his extended family, meant to feel confident in it?

I think what's key in all of this also are relationships, and it was really clear to me when I met -- I had the meeting on 13 August, given that Liam and the consultant had been in dialogue, had been meeting, had come across one another for the best part of six months by that stage, and there was just no semblance of relationship between them and, look, not every, not every relationship works, I absolutely accept that. But if it's -- I think, even more for mental health compared to physical health, if the relationship isn't there, then the confidence won't be there. That undermines the stability, I think, of the patient in terms of how they believe they are going to get better.

And I just, I -- I just feel the culmination of that really just meant that there was that underlying lack of confidence and, therefore, probably trust in what was

being said to him, as I say, around his diagnoses.

I think also when there are -- and I'm presuming that Liam would have had these various diagnoses communicated to him, and Liam, I think, as an individual was quite a literal person, the kind of person that, if you said you were going to meet him at 4.00, you had to meet him at 4.00, okay, not quarter past, it was 4.00. He could be late, by the way, but ...

But in that sense, if he's hearing a different form of words each time, that's telling him they don't know, and the way I equate it in my mind is that somebody can start off with a cough, so if they have got a chill, a cold, the beginning of Covid, the beginning of pneumonia, flu, it could be, it could develop into any of those things. The treatments for those will be slightly different but the outcomes might be certainly different.

So, therefore, if all of these different diagnoses are taking place, how do we know at any given point in time that we know that the severity or the nuances shouldn't lead to a different treatment plan being followed or, alternatively, and I would accept this too, that they are actually all variations on the same theme and they all add up to the same thing, but in the absence of any explanation, we don't know.

Q. No, and do you think that that had any impact on his treatment in terms of the way in which he received it?
A. I think on one level, who knows, okay, because certainly in terms of, for example, prescription or psychiatric or psychologist support, it may, it may not have had an impact, it depends on whether they were variations on the theme or quite different, quite different diagnoses.

What certainly didn't work, regardless of the diagnosis, was the mechanics of the treatment plan.

Q. Yes. We will go on to that in a moment.
A. Yes.
Q. Thank you. But before we, in fact, before we go there, if I could ask you in relation to the second concern, which is the ward environment. Now you have spoken in your statement for some length regarding the environment of the ward, you reference the activities and the food that was provided and, although you are not, it seems to me, overly critical of the ward environment, you do suggest that Liam sought to discharge himself in part because he didn't think that it was one that was conducive to his recovery.

First of all, is that right --

A. That is correct.
Q. -- and, if so, what do you think it was about the ward environment that wasn't quite right?

A. Okay, the first thing I should say is I didn't go into the ward myself. When Liam and I met, when he was in hospital, he was always well enough to be able to walk around the hospital estate, as it were, so we were free to do that.

Liam sometimes referred to the activities that they were asked to do and some of them he thought were quite good, quite interesting, and others he just thought were plain silly and childish. I think that, certainly from what Liam told us and from what a couple of family members who did go into the ward saw, was that there were a whole range of people there with very differing behavioural traits that could be regarded as quite intimidating or even frightening.

Liam, in his -- just in his way, you know, said he was one of the few "normal people" there and I mean that as no -- in quoting Liam, I mean that as no disrespect to any of the other patients who were there and nor do I mean any disrespect to the Inquiry in saying that.

But, nevertheless, he felt perhaps he was one of the less extreme, shall we say -- less extreme behavioural traits and, where you have such a range, within a necessarily confined environment, it is no wonder if somebody feels better than when they were admitted, they might want to then accelerate their own discharge, even

though it might, it may or it may not be the best thing for them.

I just felt, I suppose, that particularly in the earlier times when Liam went in, he actually just needed a short period of stabilisation and then he came out again and he was fine. But I'm not sure that anything happened on the ward that actually helped him regroup, in the sense that he came out knowing what was wrong and how he could deal with things going forward. It was very much a -- I suppose I have termed it as a holding pen, where a whole group of people with disparate needs were housed for a period pending something else happening.

I think in my statement I have also made an observation, it's not necessarily a criticism, but it is an observation that it was a mixed-sex ward. Liam formed a friendship and an attachment with somebody who probably he felt was quite similar to him, in terms of needs and kind of, perhaps, diagnosis, and they formed a friendship that certainly, on the face of it, seemed to be good for both of them.

When you have got a group of -- I suppose my observation would be for the Inquiry to consider that, when you have got a group of vulnerable people together in an enclosed environment, whether such attachments are

perhaps inevitable, sometimes they will be for the mutual good but one can also imagine circumstances in which it might not be a healthy attachment or, if those attachments go awry, there will be a fallout from that which, in itself will only complicate the issues being felt by both parties.

So I am not saying it's right or wrong. Obviously the Inquiry will see the aggregate of everybody's observations and come to its own conclusion accordingly.

Q. Thank you. Before I move on to the care management plans, which is the third concern, I wonder whether, is it right that you feel that Liam's case is one where he would have been better treated in the community, essentially, but that the community support simply wasn't there for him or wasn't there at the right level for him; would that be fair?

A. Okay, so I would make two points there, I suppose. What was -- in terms of the treatment or the care plan, rather, itself, it seemed to consist, to a certain degree in Liam's case, of prescription plus community activities and support and, in Liam's case, also accommodation.

So I suppose there are three elements to pull together to make the whole thing work for Liam. Of course, the fourth element is Liam himself.

The person who is key to all of that is the community psychiatric nurse role. They appear to be -- as far as the plan is concerned, they are the person who you can regard as either pulling it together or making it happen, and so much success of the treatment plan, I think, relies upon obviously that individual being conscientious about their job and being sufficiently skilled to deliver it, and having a good relationship with what they would call their clients, in this case Liam.

I think the second part of the going to your question about support in the community, I don't know whether the prescriptions that were set out for Liam were the right ones or not. That would be a -- that's much more of a clinical question.

I think though, what Liam really needed was help with those occasions in life when he thought things were getting bleak, when he could see this kind of dark period coming up. How could he, what triggers could he use, what, if you like, almost management tools could he use or could he employ to help him through those moments. We all have techniques that we use every day, all of us, to do things like that and we don't regard ourselves as having mental health conditions, but they just help us cope with certain situations.

Liam lacked those and, therefore, needed support and guidance to develop them and then to practice them and then to use them. And that seems to have been entirely missing from the care plan.

Q. Would it be fair to say that the care plan was sort of presented to him as a product, he wasn't necessarily involved in developing it and, whilst he didn't necessarily have an issue with the care plan, per se, it was the follow-through of the care plan that was the problem in his situation?

A. Yes, I think, I think in Liam's case, he -- I mean, I suppose he wanted to have input in terms of the diagnosis because he wasn't confident in it and he had his own alternative, which may or may not have been wide of the mark. But I think he would have been happy to have been presented with a care plan and would have believed in it, if he had thought that the follow-through wouldn't happen.

What was clear, as 2012, particularly, progressed -- actually, no, it's fair to say in 2011 also, that just that lack of follow through, the lack of having someone he could reliably call upon, you know, an example of being -- even like the fact that you have a crisis line given to you to call in the event of you, you know, knowing you are feeling bad, and all you get is

an answer phone, that's not what's -- that's not particularly helpful at all.

I think on at least one, if not two or three, of the occasions that Liam was admitted to Chelmer, it was on his referral, and he was never taken unwillingly there. So he knew he needed help but it was just how to access it at the time that he needed it, and it wasn't just he who found that, it was NACRO as well.

Q. Yes, hence the two unanswered --

A. The two unanswered calls on 2 August --

Q. Yes.

A. -- and on 13 August.

Q. Yes.

A. I think a conversation between NACRO and the community mental health trust did take place on 3 August, in which it was really NACRO just setting out that, in certain circumstances, we are going to need your support and help --

Q. Yes.

A. -- so, basically, can we have it please?

And then, of course, just 10 days later, they did need it and, okay, on that day it turns out that the community psychiatric nurse was off sick and anybody can be off sick. But, well, surely to God, there is cover in place, and it's incredible that we, you know, through

the medium of an inquiry, we have got to suggest that that might be --

Q. Yes.

A. -- a good thing to have in place.

Q. Yes.

A. I think, if I may just say one of the other things about the care plan that struck me. I have no experience, other than through Liam, of even seeing a care plan. But in most other walks of life, if you have a plan to do something, quite early on in that plan, you actually set out what you are trying to achieve, what the objectives are or, even in more clinical parlance, what the outcome should be.

Nowhere, in any of the versions of the care plans that I've seen from the hospital notes since, have I seen it set out anywhere what a good outcome would be for Liam.

Q. Right.

A. Because, if you don't have that objective or vision really set out, right at the beginning, how do you even know what you are working towards? And I think that is -- it just plays into this whole firefighting regime, where the Trust seems to devote its attention and resources to just conveyor-belting patients through Chelmer Ward, without actually stopping the conveyor

belt and saying, "How can we prevent this from happening again? What is it we need to do? And what can this patient, given all we know about them, reasonably expect as a result of a treatment plan that's set up with a fair wind?"

Q. Yes.

A. I did have a discussion, post Liam's death, with -- when I met again with the "Making Experiences Count" manager, I think this was in January 2013. But she brought with her to the meeting a member of their substance and abuse team, who I think, I believe, was a psychiatrist and I hadn't met him before that. But he was very forthright with me about what I should have been able to expect Liam to do and for the Trust to do. And one of the points that I made a note of, and I have come across it since, was that he said that substance abusers who don't have an underlying mental health condition can't get out of this cycle by themselves, they need help, which cuts across what was being told to me on 24 April and goes to the point, I think, that was made actually in the opening remarks by Counsel to the Inquiry about having a mental health condition shouldn't be regarded as a terminal illness. And there's an email from me back to that -- back to the Making Experiences Count manager after that meeting, in which I thanked that

person for their directness and honesty and for also making clear that, for vulnerable people, death was not an inevitability.

Q. Yes. I suppose even if individuals who are struggling with substance abuse without mental health conditions need help, then what does that say about those who also have mental health conditions?

A. Well, I imagine it can only be worse. But that's -- but I think that, allied to the fact that then if people involved in delivering that care plan don't step up to the mark and I think, in Liam's case, the role of the community psychiatric nurse frankly failed.

Q. Yes.

A. There were several instances of Liam telling me that he had failed to make -- keep appointments. His mum, at the time, confirmed that to me as well and she was exasperated by it. There is a note in the hospital records in February 2012 saying that that person was meant to attend a meeting and didn't. I have already mentioned that he didn't attend the meeting on 24 April either.

He couldn't be contacted on 3 August, nor could he be contacted on 13 August. At least three of those were critical or pivotal moments in Liam's particular timeline.

Q. Yes. Thank you. Still on care management plans, I have one more topic to cover with you in relation to that which is your involvement and Liam's mother's involvement. Do you think that the level of your involvement was appropriate?

A. I think we had got to the stage where, during 2011, when we were just -- as I said earlier, I think we were desperate for professional help: us wanting to help Liam, us wanting him to get better was not enough. We needed help. And we would have been happy to leave that to the professionals if we felt that they were getting a grip of it.

I got involved on 13 August because I think Liam felt he wasn't getting anywhere and he asked me to attend that meeting because he thought perhaps I could be more assertive on his behalf to move things along and I -- really, I came out of that meeting just feeling, well, just knowing how difficult it was for Liam to move it along, which is why, then, when the opportunity or when we created the opportunity to have the 24 April meeting, we thought it's all or nothing on this and, as I mentioned, we just came out of it feeling we were at an impasse.

If we had the answers we would have input them into the care plan. But we didn't know what the answers

were.
Q. And --
A. And, actually, we didn't know what the problem was, the underlying -- if we had certainty about the underlying problem perhaps we would have, through our own research, had a bit more certainty about what we would have liked to have seen happen in response to that. We had to get involved but I appreciate that Liam, you know, by that age was a 28 year old adult. So you wouldn't necessarily automatically expect the parents to be actively involved necessarily in a care plan like that. Although I would have hoped, by the fact that both Liam's mum and I attending meetings, we showed we were happy to be actively involved.
Q. Thank you. If it's all right with you, I propose to deal with one more concern, which is the concern about his treatment, before perhaps taking a short break and then --
A. Okay.
Q. -- and then finishing the concerns and dealing with your recommendations; is that all right?
A. Of course.
Q. Thank you. Now, in terms of his treatment there are two points really that -- well, three, in fact, that it seems you make in your statement. The first is in

relation to prescriptions?
A. Yes.
Q. Now you refer to issues with the GP being the gatekeeper for medication, in situations where there has been a referral to a specialist. It strikes me that your concern here is really to do with a disconnect between the different services; is that right, and do you have anything further to say about that?
A. Okay, so it was only as a result of the seven-day report that came out after Liam's death, that the person writing that report had actually highlighted that there was a discrepancy between what Liam's consultant psychiatrist was -- at one point there was a discrepancy between what the hospital were prescribing and actually what was on Liam's record at his GP.
Q. Yes.
A. It turns out that the process for communicating a change in the prescription was that the community psychiatric nurse should ring a GP's practice and say there's been a change in the prescription, this is the new prescription.

Because the CPN couldn't get hold of the GP, on that -- on a given date, he sent a fax, but it didn't appear that that fax had actually been actioned.
Q. Right.

A. Which strikes me as a completely barmy way of updating a prescription, even allowing for how technology has moved on since, emails were very much the order of the day in 2011/2012, and why it needed phone calls -- you can imagine there is just so much scope for things being taken down incorrectly, even doses, whatever.

It, it just sounds a completely wrong way of doing it, as well as being extremely time-consuming and not particularly timely either.

In terms of -- when I got a copy of the hospital file eventually, I found an exchange of correspondence between the consultant psychiatrist and the GP, where the GP had raised an issue about whether the prescription that the consultant had suggested was, in fact, the right one. So that tells me that even on one particular level there is a -- there was a level of professional disagreement.

So to the first issue, it's really about a process and there's got to be a better process than the one that was in place.

In the second process, in the second issue, again it just goes to underline, I suppose, my lack of confidence as to whether the clinical team at the hospital really had their arms round this.

Q. And whether he, in fact, got right prescription?

A. Indeed.
Q. Yes. We have spoken to some extent about the lack of psychological support for Liam in the community. Is it right or is it your understanding that prior to the April meetings, there was no one-to-one counselling in the community for Liam?
A. That's correct, yes.
Q. So that only came in place once the complaints were put in, essentially?
A. Yes.
Q. Yes. Now, also in your statement, you set out that Liam instructed with addiction during his teenage years and thereafter, and you provide a bit of context to that, relating to kitchen shifts, which can be very full on --
A. Yes.
Q. -- and how it can be quite difficult to wind down after work, and that might be where the alcohol seemed to help him to begin with?
A. Yes.
Q. It is right, isn't it, that he received some support from ADAS but he did not receive any specific addiction-focused treatment?
A. No, he didn't. Liam was told, and I was aware of this, that he should reduce -- attempt to reduce his alcohol and substance intake, particularly when he had been

admitted for those -- as a result of those very things. And, indeed, again from the hospital notes that I've seen since, they say that the patient has been advised to reduce his alcohol and substance intake but, beyond actually just telling him to do it --

Q. Yes.

A. -- I think people need support sometimes to do that. Not everybody can just resolve to make that decision and then follow through with it, and that was just reinforced in my mind when I met a member of the substance abuse team at the meeting in January 2013 and that's not being, I don't think, smart after the event. I think what one suspected was actually borne out then by a professional.

Q. By "suspected", do you mean suspected that he should have had this treatment and he didn't have it?

A. Indeed, yes.

MS PUCKS: I understand. Thank you. I wonder whether now might be a good time to break, Chair?

THE CHAIR: How long were you suggesting?

MS PUCKS: 10 minutes.

THE CHAIR: 10 minutes, very good.

(3.52 pm)

(A short break)

(4.04 pm)

THE CHAIR: Ms Pucks.

MS PUCKS: Thank you, Chair.

We were just about to start your fifth concern, as set out in your statement, which, in fact, you have answered quite a few of my questions in relation to but there is one outstanding question and here we are really dealing with the cycle that Liam found himself in.

I wondered whether you could tell us a bit about your impression of the communication between inpatient ward staff and the community staff?

A. I am not really sure how that worked. I imagine that the treatment plans that were set out, that somehow the CPN, who was the person pulling all that together, would have received a copy of the treatment plan because there were a list of people at the bottom right-hand corner on the plan showing who the plan was distributed to, although, on one particular occasion, I think it was following our meeting on 24 April, it said that a copy of the plan had been distributed to the parents.

Q. But it wasn't?

A. I didn't receive a copy. I have since asked Liam's mum whether she can recall receiving a copy and, to the best of her knowledge she -- or recollection, I should say, she didn't.

Q. Right. So is it your evidence that, essentially, you

were not aware of what communication, if any, there was?
A. That's correct.
Q. I'm grateful. If I could now move on to the last concern and this will be broken up in three parts, and this really relates to the time period after Liam's death. First, I want to talk to you about the immediate post-death --
A. Yes.
Q. -- then the inquest, and then subsequent discussions that you had with the Trust. What took place after Liam died on 14 August?
A. Excuse me. The next day, Liam's mum and our daughter went to a local funeral directors to try to start making arrangements but neither Liam's mum nor our daughter, or indeed I, although I wasn't at that meeting, were aware of where Liam was and the funeral director took it upon herself to try to find out and found out that his body was at the mortuary at Princess Alexandra Hospital. Once we found that out, we then made arrangements to go and see him.
Q. You have also previously referred to the manner in which you found out that Liam had died. In hindsight, what do you think of the manner in which you were spoken to and informed of matters in the days that followed his death?
A. Well, certainly, from my own perspective, I had no

contact from the Trust or NACRO. The police were in contact with Liam's mum (a) because they informed her that Liam had been found dead and (b) they had formed the view that there were no suspicious -- or reasons for them to investigate further.

And I made contact with the police then on a couple of occasions to arrange a meeting, so that I could understand what they found because I just felt I didn't know enough about the circumstances around his death to feel at least that I knew what had happened. They felt they had -- initially, they had covered all that off with Liam's mum, which they had. But I wanted to hear it for myself and, eventually, they agreed to come round to our house and we met one evening for a short period and that was fine, and then we saw them again at the coroner's inquest.

But I think that it seems remarkable, doesn't it, that someone should have died in the care of a health authority and that no member of our family received communication from the health authority, although I found out later, via the seven-day report, that some counselling support had been offered to Liam's mum, which is absolutely fine, but not to any other member of our family.

Q. Yes. I would like to ask you some questions about that

seven-day report, if I may?

A. Yes.

Q. Without telling me the names of anyone, do you remember in what circumstances you were made aware of its existence?

A. It was during -- it was early in 2013, I was having conversations with the Making Experiences Count manager, that led up to a meeting with her and she said, in passing, have you seen the seven-day report because it was clear from our conversation that it obviously triggered something for her to say it. And I had never even heard of a seven-day report, so she arranged for it then to be sent to me. So that was the first I knew of it.

Q. You set out in your statement that you had numerous concerns about the report. I wonder whether I can briefly summarise --

A. Yes, of course.

Q. -- my understanding of your concerns and then ask you some general questions about it.

You were concerned about the use of initials, which you said goes to the point about candour and accountability?

A. Yes.

Q. You were confirmed in your understanding that Liam's

diagnosis had been bounced around. Through the seven-day report, you became aware of the disparity in relation to his prescription?

A. Yes.

Q. You were concerned about the selective nature of the content. There was a general attitude of, "We did our best and it was because of his substance abuse and the like". There was no mention of the two meetings that you attended. There was no mention of the complaints made. There was no mention of the unsuccessful calls to the CMHT in the week before his death, the 6th -- I think it was 3 and 13 August, in fact. And there was suggestion in the report to effective collaboration, which you dispute was, in fact, effective. There was also a suggestion of effective follow up and the use of supportive interventions, which you disagree with.

The report also highlighted a discrepancy in the time of death. It made speculative conclusions about Liam's intention before any toxicology or coroner's report and it made only very narrow recommendations essentially to do with paper records only.

Is there anything else that you would like to add in relation to these concerns?

A. You summarised them very clearly and that, that's fine. I suppose it's worth, from my point of view, clarifying

that we talked earlier about the cycles and I think it's important to say that Liam had periods in between of those when he was perfectly fine and our interactions and all of that confirmed that.

When he started going into his dark periods, if I can express it that way, it was then that he resorted to things like alcohol and other things, rather than that being a constant feature of his life.

So in other words, they were the tools he was using to try to get out of those periods, in the absence of having any, frankly, better tools to work his way out of them. So I think it's worth clarifying that.

I think, in terms of how -- this idea of collaboration, I would suggest, for example, the interaction between the hospital and the GP was an example of when it didn't work. The failure of the CPN role was another example of when it didn't work. The fact that NACRO couldn't get the help they needed for Liam when it was needed, that didn't work. And you may even go as far as to say, so what was the role of NACRO in terms of what was expected of them as the accommodation providers and was that working?

And how can any of this be assessed when you haven't got a set of objectives or outcomes that were the target that everybody was aiming for.

So, against that, there is nothing to measure about whether what the hospital or what the Trust was doing for Liam was actually working.

There is a section of the seven-day report which talks about general risk assessment, I think, and that claims that there had been good risk assessment in place and it merely went on to list, essentially, a number of the reasons why it was perhaps inevitable that Liam had died.

I would then go on to, I suppose, say that, in summary, they -- as you have rightly said, the person writing the report has speculated what might have happened and that's before any toxicology report had been received or, indeed, the coroner's inquest had taken place and it is their role to determine that, as is my understanding, that they had seen good collaboration taking place: an example of that in the report, they say, was Liam's mum being offered support when it was needed.

This report was about a 29-year-old man who had died. Its one concrete recommendation was that electronic papers should be filed the right way up in the Trust's systems so that they can be easily accessed and read.

When I challenged that at the coroner's inquest

I was told that that was actually very important. And it might be. But if any individual of a relatively young age dies there must be more to learn than just that. There must be. Because Liam's wasn't an expected death. It wasn't even a death that should have happened. If he had received, I think, the help in identifying the coping mechanisms that he needed for day-to-day life, I think he would have stood a very good chance of coming through the dark periods that he experienced. And, frankly, I am not sure who gains out of a report that says, after all of that has happened and it's taken us a long time to go through all that's happened just at this Inquiry, and the thing we learn is that we have got to file the papers the right way up.

That doesn't reflect well on the Trust. That doesn't actually help the professionals in the Trust do a better job; it doesn't help our family; and it doesn't help future families.

Q. Thank you. I want to move on to the inquest if I may.

A. Yes.

Q. Liam's inquest was held at Chelmsford Coroner's Court before Mrs Caroline Beasley-Murray. Did you engage in this inquest?

A. I did, yes.

Q. Yes, did you have legal representation?

A. Sorry legal representation?
Q. Yes.
A. No.
Q. No, did you receive any kind of guidance or support in the process?
A. I received a booklet of several pages describing what a typical inquest does, what its remit is and what the protocols were on the day.
Q. Could you tell us a little about your experience of engaging in this inquest, please?
A. So, on the day, we arrived at the inquest and actually it turned out that there were quite a few family and friends who were there to support us on the day and we were in quite a small room, as it turned out, with members of the Trust, which made for a pretty tense environment prior to the inquest taking place.

Then a gentleman came in to just say that we were to be respectful at all times and he didn't want any raised voices, or anything like that, taking place at the inquest. I don't know if that's because he could sense it was going to be emotionally charged, but that's what he said anyway, and I am not sure, I know at the time it wasn't a particularly helpful intervention, it may have been regarded as a necessary one, I don't know, but we are quite polite people. We didn't intend to behave

badly.

So the inquest then took place and the coroner set out her remit, which was very narrowly to define who had died, why they died, when they died, how they died, but crucially not why.

Q. Do you have any views about the remit of a coroner?

A. I think that it was clear and it would be clear to the Inquiry from the transcript of the Inquiry -- the inquest -- that I have shared with the Inquiry that we had questions arising not just from the seven-day report but the whole manner of what you might regard as Liam's treatment plan and, indeed, the manner of his death and what happened around that.

And I felt that, with my interactions with the Trust right from the beginning, I had little confidence that there wouldn't be a whole raft of people appearing before similar inquests because I told the coroner's hearing that, in my view, the position of other families was going to be just as we found, which was hopeless, literally without hope.

I -- and I -- it was clear at the coroner's hearing, that the representatives put forward by the Trust to speak on their behalf, first of all it was meant to be the previously mentioned operation -- Operational Service Manager, who at least did know Liam's case but

she was on holiday, couldn't attend and, therefore, this other person was, was put forward in her place.

I think such a critical person representing the Trust, that perhaps should have been grounds for a delay to the inquest hearing. Anyway that didn't happen.

I felt that the person they did put forward was intent on damage limitation to the Trust and, as I mentioned earlier, defended the seven-day report by saying that that particular recommendation was an important one for them to follow but she really wasn't briefed on Liam's case and, on one particular occasion, I had to remind her of Liam's name. And it just highlighted to me just the lack of seriousness, I suppose, with which the Trust treated both Liam's death and the inquest. And, as is borne out by the fact this Inquiry is even in existence, I wasn't wrong when I said there would be others.

On reflection, given that this Inquiry covers the period 2000 to 2023, so we were 12/13 years into that period and we are talking about the Essex mental health trust here and, therefore, deaths in Essex, who or why wasn't the coroner's office beginning to join some dots and asking itself why are we having to have so many inquests for people who die unexpectedly, given they are in the care of the local health authority?

And if families like ours can't rely on the Trust to live up to a duty of candour, perhaps we will come on to that, and we can't rely on coroners' courts to question what's going on, where are we meant to turn to to make sure it's better in the future?

Q. The inquest, is it right that it resulted in an open verdict, with the cause of death being mixed drug overdose and there was also generally an encouragement for discussions with the Trust to continue. How did this conclusion make you and your family feel?

A. I have no argument with the open verdict. I mean, it's -- from any family's point of view, it's not a satisfactory one. But I understood the coroner's line of reasoning in coming to that conclusion.

At the time, probably, I wasn't in the frame of mind to argue back the point about keeping talking but, in retrospect, that is incredibly lame, and I mean there have been many instances since where I've read both online and in the press about coroners giving their opinion or saying that something here doesn't seem right, and it should be investigated further, or something like that, and I have often thought, "Why didn't our coroner say that?" Or, even if our coroner didn't think it was the right thing to say in the inquest at that point in time, why didn't the coroner's

office instigate something that would have been helpful to future families?

Q. Thank you. I wonder whether we can now move on to any discussions that took place with the Trust after the inquest and I am thinking, in particular, of the meeting on 8 April, which you have already referred to. I wonder whether you could tell us more about that meeting?

A. We had had an earlier meeting in January which had -- you know, we clarified a couple of points but there were still a number of points outstanding, so I wrote to the then Chief Executive Officer, asking to meet him, listing a number of points that I wanted to raise with him, given that I felt that -- given that they, I felt that, you know, they had not been answered to date, despite my emails and previous -- a previous meeting.

They acknowledged my letter and, eventually, the Chief Executive Officer came back saying, "I have asked two members of my team", one of which was the lady who represented the Trust at the coroner's hearing and another of her colleagues too, to meet with me. My daughter and I attended that meeting and we, I suppose, in the form of an agenda we went through those individual points one by one.

I had requested a copy of Liam's hospital file,

which by that time, by the time -- between the letter to the Chief Executive Officer and the meeting I had received that, so I had a chance to work my way through that. I wanted -- I wanted them to acknowledge that some of their actions and processes really just hadn't helped Liam at a time when he needed help. I just felt that the Trust hadn't used this as an opportunity to genuinely learn lessons, when an organisation like NACRO had and, of course, I had a number of misgivings about the seven-day report that we have just gone through.

So that was, that was why we wanted the meeting and what we wanted to cover with them.

Q. As the father of a young man who died whilst under the care of the Essex Trust, do you feel as though the manner in which you were treated during these discussions was appropriate?

A. I think it was true then, and I still feel it in retrospect now, that there might have been a superficial attempt to learn very limited lessons, such as, you know, the process for dealing with prescriptions for example, prescription changes and how that might be improved.

But we have already mentioned, for example, that on 13 August, the day before Liam was found dead, NACRO had contacted the Community Mental Health Trust and the

query or the request for help had been put in a message book and what kept coming back to me -- and this was reinforced by a member of the -- by the director who attended the meeting on 8 April -- was that, had the word "urgent" been used, that might have got a different response. It meant that the duty worker, whoever that might be, might then have picked that up and phoned NACRO back.

I -- I just -- it just -- I mean, from my career, okay, I know what corporate defensiveness looks like and feels like. Unfortunately, I have had to do it in the past, so I know it when I see it. In fact, the first thing we said when we went into that room is, "We are not here looking for compensation from the Trust", because I knew that -- or I felt that everything up to that point had been about -- around liability management, and the body language of that director visibly changed in front of me to a more relaxed pose when I said that.

It shouldn't take that sentence for everyone, as fairly rational adults, to try to learn their best from a bad situation and, as I said to the Chief Executive when I wrote that letter to him requesting the meeting, the defensiveness of the Trust at the time only managed to make what was already a very bad situation worse, and

that is what the Trust had managed.

Q. You previously made reference to the duty of candour and you said that we may come back to it, and I wonder whether we can do that now before we move on to recommendations for change. Was there anything that you wanted to say about the duty of candour?

A. I mean, I am aware of it because -- subsequent to Liam's death I am aware of it because I was trust -- later on, I was trustee and chair of a hospice. So duty of candour was one of the principles that, although we weren't formally part of the National Health Service, we adopted because so many of our staff were ex-National Health Service and, indeed, it seemed a good principle to work by.

But it's not a principle that you can pull out of the drawer when it's required. So, in other words, if something bad happens, you don't pull it out and then throw it around as a phrase liberally to show that you are going to try to get to the bottom of it whether you are going to try to or not. It's actually an ethical code by which you live in your working environment. And it presupposes that you -- that every day is a school day and that you are going to learn professionally, both in terms of your continuing professional development but also in terms of genuinely understanding when things go

wrong, hold your hands up, and let's make sure it doesn't happen again and put changes in place that ensure that doesn't happen again.

Q. Thank you.

A. At no time did that approach appear to be exhibited ever by the Trust in my dealings with them, if I may say nor since in their representations that I've seen to this Inquiry.

Q. Thank you. You set out that your primary aim and your involvement with this Inquiry is to contribute to a list of recommendations that will hopefully improve the quality of care for future patients with mental ill health and, unless there is anything else you wanted to say about the concerns we have raised so far, I wonder whether we could now turn to your recommendations which are at paragraph 86 of your statement.

I wonder if we could perhaps take them in turn. The first that you set out is mental health equivalency and you state that mental health needs must be viewed as and treated as equal to physical health. Is there anything additional that you would like to say in relation to that recommendation?

A. The analogy I draw when trying to rationalise that to myself, because I understand that this is actually in law, but the analogy I draw for myself is, if I break my

leg, and assuming it's not too difficult a break, I am pretty confident it's going to be fixed. If I have a mental health condition, I am not equally confident that I will come through the other side the way I would like to.

Q. Your second recommendation relates to a patient-centred service and the adoption of a principle that there is essentially one patient, one plan, one accountable clinician and one agreed set of desired outcomes. Is there anything further that you wanted to say in relation to that recommendation?

A. No, I mean, in my working life, whenever you have got a plan, you have always got an accountable individual. I can understand if people think that having an accountable individual means that we have got someone to blame, that's not my reason for saying it and, if somebody is uncomfortable with being the accountable individual, my suggestion would be that perhaps they are not right for that role. Okay. I think if you think of all the different moving parts around Liam's care plan, okay, so the hospital, the CPN, the GP, NACRO, psychologist support that was coming on board, everyone has got to know what they are working towards.

It's not about them doing their individual bits that don't necessarily complement the other parts of the

treatment plan. So that's why it should be really clear both to the professionals and to the patient, of exactly what we are trying to achieve here, and that all the individuals involved in it should buy into it and, if they don't, then they are not part of the plan.

Q. The next one is a non-judgemental approach. You essentially set out that acknowledging that some lifestyles may not help, mental health issues are not and should not be seen to be the fault of the patient, essentially; is that a fair summary?

A. That is a fair summary. I mean, I mentioned earlier about some of the relationships not being as they should be.

Q. Yes.

A. You just can't help feeling is there an element of judgement that's, that's gone into that. That's really got to be put to one side.

Q. Thank you. There is then the duty of candour and lesson learning, we have just discussed this. You state in your recommendation that the NHS should genuinely embrace this duty of candour and not just display it as a cultural value that exists for PR purposes only; is that a fair summary?

A. Yes.

Q. You have referred to -- well, you state, "One must

communicate clearly and abandon jargon". You state that acronyms are difficult to understand and also you question phrases such as "service users", "outpatients unit" and job titles like "Making Experiences Count manager"?

THE CHAIR: For what it is worth, I am deeply sympathetic to that last point.

A. Even, I think, referring to patients as "service users", I think patients regard themselves as patients, but it extends to thing likes the seven-day report, which I said were covered in acronyms. So how someone outside the profession is meant to understand that.

MS PUCKS: Yes. You state that if an NHS Trust is going to apologise they should do it properly no, "I apologise if", but rather "I am sorry"; is that right?

A. There are examples from the letters I have shared with the Inquiry where I think even the Chief Executive apologised "if" I thought somebody's actions had not reached the standard that I expected; what about the standard that the Trust expected?

I think also, when the Chief Executive Officer followed up on the meeting I had had with his colleagues, he picked up on a point made by one of the people at that meeting that Liam's issues were complex. I refute that. Liam had dark periods, yes, I accept

that. He just didn't have the coping mechanisms that the Trust could have provided to deal with them. To me, that's pretty basic and, compared with things we hear and read about other people's trauma and the support that they receive, this is a very, very straightforward case in my view.

Of course, there are a number of moving parts and now I come to another recommendation, but that's not of Liam's making. That's what the Trust chooses to do and how it chooses to deliver its service. So, in other words, Liam's issues were not complex, the manner in which it was being delivered was complicated.

Q. Yes, thank you. You give, as a recommendation, that agencies must be fit for purpose and you give a specific concern in relation to NACRO and wondering what value NACRO brought; is that right?

A. Yes. So, of course, outsourcing in some circumstances is both necessary in order to buy in expertise. I suspect occasionally it is used for cost-cutting measures. But, in any event, that doesn't absolve the Trust from making sure that they deliver a service in line with the patient plan to the standard the Trust has set itself, and it should ensure that anyone or any organisation it uses can and will and, on an ongoing basis does, deliver service to the right standard and,

in NACRO's case, I merely raised this because what was their role? Was their role to merely provide accommodation, in which case why were they providing accommodation, rather than any other organisation? Or again, rather like the ward or rather like other places where Liam stayed, was it really just a holding pen of people with issues who might not be good for each other?

Q. Yes. Thank you. There are four more recommendations. Invest in technology, and we have spoken about the use of hard copy letters and fax. You then recommend -- well, in relation to leadership and professionalism, you ask for empathy and that those who seek leadership rules are qualified, that they are professional, committed to patient care and genuinely want to work in the area of medicine, I think is what you are saying there?

A. Yes, and this goes right to the very top of any organisation but we are talking about the Trust here.

Q. Yes.

A. The leadership of the Trust has got to be empathetic to the patients that they have the responsibility of helping.

Q. Yes, yes. You also ask that family members are treated equally and you have given some evidence today and also in your statement about some of the differences in which you and Liam's mother were treated. You give us the

example that correspondence was generally sent to Liam's mother and also she was offered emotional support following his death, whereas that support had not been offered to yourself?

A. Yes.

Q. Finally, in relation to inquests, you recommend that the Trust put forward representation at inquests that is appropriate, that are appropriate, and also suggest that coroners perhaps should have more powers to address the issues that they hear about in relation to particularly recurring themes; is that right?

A. (Witness nodded)

MS PUCKS: I am incredibly grateful to you for the evidence that you have given. That completes the questions that I have.

Chair, do you have any questions?

THE CHAIR: I have no further questions.

MS PUCKS: I am very grateful. I wonder whether we have a photograph of Liam that we would like to put up for a few seconds, following which we are going to have a break to ensure that there are no more additional questions for you. If there are no more additional questions for you, then we will rise for the day.

A. Okay, thank you.

MS PUCKS: If there are, then we will come back to ask those

but if I could ask that the picture be put up, please, thank you.

A. Thank you.

THE CHAIR: Mr Brennan, thank you very much indeed for your evidence. We have worked you very hard but you have given us a lot to think about and I am very grateful to you.

A. Thank you, thank you, Chair.

MS PUCKS: Chair, just very finally, tomorrow, we will be resuming at 10.00 am and we will be hearing from Lydia Fraser-Ward and from Alan Oxton.

THE CHAIR: Thank you, Ms Pucks, thank you very much indeed.

(4.49 pm)

(A short break)

(The hearing did not reconvene)

(4.55 pm)

(The Inquiry adjourned until 10.00 am,
on Wednesday, 9 July 2025)

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