Witness Name: Patrick Brennan

Statement No: 1

Dated: 4th June 2025

THE LAMPARD INQUIRY

Witness Statement of Patrick Brennan

I, Patrick Brennan, will say as follows.

Preliminaries

1. My full name is Patrick James Brennan.

2. I am making this statement about my son, Liam Patrick Brennan, who died on Tuesday 14 August 2012, four days after his 29th Birthday.

3. I have previously given a commemorative statement to the Inquiry about Liam and the impact his death has had on me and my family. This statement will address the details of the care and treatment provided to Liam by North Essex Partnership NHS Foundation Trust ("NEPT") and my concerns about that care and treatment. It will first set out a chronology of Liam's interactions with NEPT services, followed by my reflections on various aspects of his care and treatment.

Liam's mental health history

4. Like many people, Liam found his teenage years difficult. When he was about 14, his mum and I split up. I think it would be fair to say that around the age of 15-16, the combination of a disrupted home life, school that he didn't enjoy, and an uncertain future meant that he fell in

with a crowd that he was happy to follow. He got involved in drinking and it probably escalated to drugs around the age of 16-17. His behaviour became trickier over time.

5. When Liam was 17, there was an incident when he took too many paracetamol tablets and had to go to A&E. Physically there was no harm done, but that incident prompted a referral to a consultant at a Priory clinic in Barnet. I am not sure why he was referred to that clinic. It wasn't the case that we were paying for it. I think the consultant he saw was called Dr [I/S] and there was a suggested diagnosis of Attention Deficit Hyperactivity Disorder ("ADHD"). Liam's mum was closer to that appointment and diagnosis as I was working in Ireland at the time, but I was happy that he was being referred somewhere.

6. As far as I am aware, that was the extent of Liam's contact with mental health services until much later, in 2011.

Liam's interactions with Essex mental health services 2011-2012

7. The following is a chronological summary of Liam's interactions with Essex mental health services in the period January 2011 to August 2012. It is based on my own recollections and the information I have obtained since Liam's death. It is not a comprehensive history, but rather a summary of the key events from my perspective.

2011

8. There were many times in Liam's life when he was in a good place emotionally. At the same time, there was always an underlying search for happiness. However, it wasn't the case that he was in a permanently chaotic state. He was able to hold down jobs, have girlfriends and enjoy music and sport. And yet, there were periods when he just felt adrift and that he couldn't quite get his arms round it all.

9. One such period came in 2011, during which Liam spiralled into a cycle of drug and alcohol misuse, followed by A&E admission, followed by mental health referral and inpatient stay, followed by discharge, and then the cycle would repeat. It seemed to be a period of firefighting, with no one ever really getting to grips with what was really wrong. Some of Liam's medical notes from that period include reference to him expressing suicidal thoughts, but two or three days later that would seem to have evaporated and he would be discharged. There didn't seem to be a plan for how to stop the cycle.

10. Liam's first contact with NEPT services was in January 2011. He was referred to Psychiatric Liaison by the A&E department at Princess Alexandra Hospital in Harlow, following an incident of self-harm. He had stabbed himself in the leg while drunk. My understanding is that no psychiatric assessment was undertaken at that time and Liam was discharged.

11. In June 2011, Liam was again referred to the Psychiatric Liaison team by the A&E department at Princess Alexandra Hospital. He had been taken to A&E by his Aunt who was worried about his alcohol misuse, low mood and occasional thoughts of suicide. Following assessment by the Psychiatric Liaison team, Liam was offered home treatment by the Crisis Resolution & Home Treatment team ("CRHT"). I am not sure what that treatment consisted of. Around the same time, Liam self-referred to the Trust's Alcohol and Drugs Advisory Service ("ADAS"). He was appointed a Counsellor called [I/S] who he continued to have sessions with intermittently. I recall Liam's mum telling me that she was pleased he was having those sessions. She seemed to think that [I/S] was someone that was trying his best for Liam.

12. Between June 2011 and July 2012, Liam received a few slightly different diagnoses. In June 2011, there was a diagnosis of *"mental and behavioural disorder due to use of alcohol – emotionally unstable personality disorder"*. I am not sure who gave that diagnosis.

13. On 10 August 2011, Liam attended an outpatient clinic appointment at Princess Alexandra Hospital with a psychiatrist, Dr [I/S] Dr [I/S] would become Liam's responsible clinician, and they would have a number of interactions. The diagnosis at that time was *"mental and behavioural disorder due to multiple drug use and use of other psychoactive substances – mild/moderate depressive disorder without somatic symptoms".*

14. In November 2011, Liam was first admitted to an inpatient facility. he was admitted on an informal basis to Chelmer Ward at the Derwent Centre, Harlow. He had been taken to A&E after being found unconscious in the street. I believe he had taken a heroin overdose. He was admitted on 2 November 2011 and discharged on 16 November 2011. At the time of his admission, the diagnosis was *"mental and behavioural disorder due to polysubstance and alcohol misuse. Emotionally unstable personality disorder, borderline type"*.

15. On 10 December 2011, Liam was admitted to Chelmer Ward again on an informal basis. He had attended A&E following another incident of self-harm. The diagnosis was the same as in November.

16. Liam remained an inpatient on Chelmer Ward over the Christmas and New Year period. He was discharged on 17 January 2012.

17. On 27 February, Liam was admitted to the Derwent Centre again, this time to Stort Ward. He was admitted following his mum having contacted the Community Mental Health Team ("CMHT") at Regent Road, Epping, to express concerns about Liam.

18. On 13 March, I attended a meeting with Liam and his psychiatrist, Dr [I/S]. Dr [I/S] was advising that Liam remain an inpatient, but Liam was keen to discharge himself. He had expressed his misgivings to me about the treatment he was receiving. He also felt that the ward environment wasn't doing him any good and that he simply felt well enough to leave. I knew he had a B&B-type accommodation in Epping (The Thatched House), so I escorted him there. Unfortunately, at that accommodation there were a number of other guys who were probably in a similar position to Liam, so it was probably not that helpful an environment either. But I thought he was at least somewhere he seemed happy and welcomed. I will discuss the meeting with Dr [I/S] in more detail below.

19. On 7 April, Liam was admitted to Chelmer Ward again. Prior to his admission, Liam had taken an overdose of paracetamol and prescription drugs before contacting the Trust's crisis line. When he called that line, he was greeted with an answerphone. He called his mum, who also tried to call it. Having also received an answerphone message, she then called for an ambulance and Liam was taken to A&E.

20. On 10 April, Liam's mum attended a care review meeting with Liam and Dr [I/S] at which they were told that support from a psychologist would not be available for a year. That prompted Liam's mum to submit a formal complaint by email, along with a handwritten complaint from Liam himself (I will discuss those complaints in more detail below). In response, the Trust arranged a meeting for 24 April to discuss the issues that had been raised. Another apparent consequence of those complaints was that appointments were scheduled for Liam with a clinical psychologist (Dr [I/S]) starting the day before the meeting.

21. The meeting on 24 April was attended by me, Liam, his mum, [I/S] ('Making Experiences Count' Manager), [I/S] (Operational Service Manager) and Dr [I/S]. My lasting impression of that meeting was the onus being placed on Liam. [I/S] was very

upfront in saying "look, Liam's got to want to get better". My response was "don't you think that's something we as a family have said?". What we needed from the Trust was help dealing with those times when Liam couldn't find that strength within himself. Liam needed support. He needed a team of people that he had confidence in to show him how to get better. If I can use a sporting analogy, you've got 40,000 fans telling their team to "get a grip", but what they need is the professional coaches showing them how to actually achieve that. Towards the end of the meeting, I addressed everyone and said that if this ends badly (i.e. if Liam comes to serious harm or kills himself) we all need to be able to look at ourselves and say that we've done our best for Liam. I felt terrible saying that in front of Liam, but I also felt that I had no other way of highlighting the gravity of the situation. This built on a point already made to the Trust in Liam's Mum's email complaint to the PCT comments email address on 10 April, in which she stated "…I wish this complaint to be investigated fully preferably BEFORE LIAM SUCCEEDS IN COMMITTING SUICIDE!!!!". It was a sign of our absolute desperation for professional support.

22. One outcome of that meeting was that Liam was offered accommodation at Nacro (an organisation that provides support and housing for people who are homeless or at risk of being homeless). He was discharged to that accommodation on 29 May.

23. On 24 June, Liam was again admitted informally to Chelmer Ward. The diagnosis at that time was *"Emotionally unstable personality disorder, borderline type"*. He was discharged on 3 July.

24. On 2 August, there was an incident at Liam's accommodation that led to him being temporarily sectioned under the Mental Health Act. I understand that there was a confrontation involving a new resident. The police attended and Liam was temporarily sectioned for his own safety as it appeared he might harm himself.

25. On 3 August, a member of the Nacro team attempted to contact Liam's Community Psychiatric Nurse ("CPN") at the Regent Road CMHT. That attempt was unsuccessful. I will discuss it in more detail below.

26. 10 August was Liam's birthday. I live with the regret of not speaking to Liam on his birthday like we normally did. We exchanged missed calls and voicemails but couldn't get hold of each other. However, I understand he spent time with his girlfriend and had a really good day.

27. On 13 August, Liam's caseworker at Nacro attempted to contact his CPN by phone. That attempt was also unsuccessful and, again, I will discuss it in more detail below.

28. On 14 August, Liam was found dead at his Nacro accommodation having taken an overdose of prescription and non-prescription drugs.

My reflections and concerns about Liam's care and treatment

Liam's diagnoses

29. As outlined above, in the period 2011-2012, Liam received a few slightly different diagnoses. In addition to those set out above, in the Spring of 2012, Liam expressed the belief that he had Asperger's syndrome. He had done some research and felt that a lot of what he thought and felt aligned with that condition. I have read reference in his medical records to him expressing that belief but there doesn't appear to have ever been any follow-up or assessment in response.

30. It felt to me that Liam's diagnosis bounced around and was inconsistent throughout his treatment. I understand that it can be hard to pinpoint what the issue is with someone. However, on the occasions I was involved in meetings with clinicians and others from the Trust, I felt that the team weren't confident in the diagnosis themselves. Liam was a bright guy and he would have sensed that. He didn't believe Dr [I/S] knew what was going on with him and that is part of what prompted him to write the complaint in April 2012.

31. Before Liam and I went in to meet Dr [I/S] on 13 March 2012, Liam said to me "you're about to see diagnosis by google". When we went in there was a projector screen and Dr [I/S] had put up a google search of borderline personality disorder. Liam didn't have confidence in the people that were supposed to be treating him and that fed into a recurring theme of him feeling let down by others. He was someone who was quite literal and the lack of confidence and clarity around his diagnosis undermined the feeling of security that he would have wanted.

Liam's admissions

32. I don't have any concerns relating to the decision-making in respect of Liam's various admissions or about the admissions process itself. To my knowledge, he was always well treated. As a parent, I simply became increasingly concerned about the frequency of them and increasingly desperate at seeing the cycle develop.

33. I do, however, have concerns around the circumstances that led to Liam's admission on 7 April 2012. As I've explained above, prior to that admission, Liam contacted the NEPT crisis line and received an answerphone message. I find it shocking that the Trust could have a crisis line with no one on the other end. The issue of the Trust's responsiveness to crisis calls is also relevant to the circumstances of Liam's death and is something I raised at Liam's inquest. I will discuss it in more detail below.

Ward environment

34. My impressions of the wards at the Derwent Centre were formed through conversations with Liam. I never actually visited the wards themselves. When I went to visit Liam, our routine was that we would meet outside and walk the perimeter of the hospital estate. I am not aware of any restrictions on family members visiting the actual wards and I know that my daughter and Liam's mum went in on one occasion. I think Liam initiated that we go for a walk when I visited because he found it helpful and therapeutic to be outside. A number of his medical notes talk about him having been for a walk and that became our routine.

35. Liam was only ever admitted on a voluntary basis, so he was free to leave the ward as long as he informed someone and told them when he'd be back. On the whole I think he would just go out for a few hours or so at most. I think there was one occasion when he returned later than he'd said he would, but other than that I don't think there were ever any issues with him leaving the ward and returning.

36. Liam didn't talk much about the ward environment specifically, but I didn't get the impression that there was much in the way of comforts. In terms of activities, he said that some of the activities they did were quite good and others were plain silly. Some things he was engaged with and others he wasn't, but I can't recall the details of those activities. I didn't have much sense of his daily routine, if there was one. Liam looked underweight when I visited him, but he didn't speak much about the food on the wards. He told me that he was weighed routinely and sometimes he would put stones in his pockets to see if anyone noticed the fluctuations, which they didn't seem to. That was his sense of humour. Part of the way he would deal with the situation was by playing games and it perhaps says something about his confidence in those providing his care that he indulged in this behaviour.

37. At one point Liam became friendly with one of the women (another patient) on the ward. He would make the odd flippant remark about other patients on the ward and suggest that she

was the only other 'normal' person there, so they gravitated towards each other. He never seemed to feel uncomfortable with the people on the ward, but he did sometimes feel that it wasn't an environment that was going to help him get better. The impression I gained was that it was like a holding pen for a group of people with a whole range of complexities and I am left wondering whether that makes sense.

38. I think it is also worth questioning whether mixed-sex wards create the right environment. When you have vulnerable people living together it may well be that they seek solace in each other, but they may also have a triggering effect on each other and issues may arise if those relationships go awry. There were certainly times when Liam was distressed about issues in the relationship he had formed while on the ward. At the same time, my daughter always felt that the woman Liam formed a relationship with was a good influence on him. I know that they spent part of the day together on Liam's birthday, four days before he died. I met her on the day of Liam's funeral, where she was understandably distressed. I do not have a clear view on whether mixed-sex wards are good or bad. I can see it is not a straightforward issue.

Liam's care management and plans

39. I didn't ever sense that Liam took an active part in the development of his care plans. My feeling was that they were presented to him as what was going to happen and his focus was on whether it then actually did happen. My impression was that he bought into his care plans despite feeling that his diagnosis was not accurate. He wanted the plans to be followed because he wanted to get better. I think he was therefore more focussed on their output than their construction.

40. I have seen some of Liam's care plans and some seem to be fuller than others. In some there are boxes that weren't completed and dates for certain actions missing. I have seen one where the distribution lists includes "parents". I did not receive a copy at the time, and I've since found out that neither did Liam's mum to the best of her recollection. When I asked, she said that she would have sent it on to me if she had.

41. My own active engagement in Liam's care management came on two occasions. The first occasion was at the meeting on 13 March 2012. The second was the meeting on 24 April 2012. Prior to those occasions there had not been any proactive engagement with me from the Trust. However, I would not necessarily have expected there to be given that Liam was an adult. I believe Liam's mum had some more contact with the Trust because she accompanied

him to A&E or called an ambulance on a few occasions, but I don't think that extended to follow-up discussions about his care plan.

42. Liam and I were both keen for the meeting with Dr [I/S] on 13 March to take place. I wanted it because I could see that whatever was supposed to be happening in respect of Liam's care plan and management clearly wasn't happening and he wasn't getting better. The cycle of admissions and subsequent discharges were becoming more frequent. Liam wanted it because he thought I would be more insistent on his behalf and because he wanted me to see what he was experiencing in his interactions with his responsible clinician.

43. My overriding feeling from that meeting was that I had doubts about Dr [I/S] professional expertise. As I've already explained, there was a lack of confidence in the diagnosis. It was clear that there wasn't a particularly helpful relationship between Liam and Dr [I/S] The meeting seemed to focus on what Liam needed to do rather than a collaborative plan for addressing Liam's needs. I got the impression that Dr [I/S] felt his time would be better used elsewhere, perhaps with a more cooperative patient. That meeting wasn't particularly productive, and nothing changed as a result of it. I think it just reinforced Liam's cynicism and I had sympathy with that view.

44. At the time, I was pleased that I'd had the opportunity to at least be part of the conversation, but it left me dispirited. I didn't come away with any confidence that Liam's needs were being met and that he was going to improve. Much later, after Liam died, I had a meeting with the Trust that was attended by a psychiatrist (I think his name was Dr [I/S]). He provided a much more assured account of what needed to happen in Liam's circumstances – what the Trust needed to do and what the patient needed to do. Listening to Dr [I/S] in that later meeting cemented my impressions from the meeting with Dr [I/S] in March 2012.

45. I have described the second meeting on 24 April 2012 above. As I've explained, much of that meeting revolved around the Trust's frustration that Liam wasn't showing sufficient determination to get better. When it came to a plan for actually addressing the underlying problems, the discussion became vague and unstructured. I didn't have much hope or confidence coming out of that meeting. However, it did lead to Liam getting the accommodation at Nacro and the psychologist appointments, and there did seem to be a better determination on everyone's part. I was left with the question: why did it take that meeting to generate some momentum to Liam's care plan?

Liam's treatment - general

46. My concerns around the treatment offered to Liam relate to, firstly, discrepancies in his prescriptions and secondly, the lack of psychological support.

47. The issue relating to Liam's prescriptions is something that I only became aware of after he died. The 7-day report notes that on 16 July 2012, there was a disparity between the prescription from Liam's GP and what the CRHT had prescribed. When I raised this with the Trust, they explained that Liam's CPN had tried to call Liam's GP to inform him of a change in medication (as per protocol) but when he couldn't make contact, he sent a fax to the surgery. The Trust's action plan following Liam's death included a change of protocol so that all faxes to GPs regarding changes in medication must be followed up by telephone. My question is why, in the era of email, couldn't Dr [I/S] contact the GP directly? It seems to me that the process of having the CPN convey changes in medication to the GP adds an extra administrative layer and widens the scope for things to go wrong. Indeed, why didn't Dr [I/S] as the lead clinician with responsibility for Liam's care plan, have the ability to directly change Liam's prescription in his records in respect of his mental health care plan? It seems that in these circumstances GPs are placed as unhelpful gatekeepers of a patient's medication, after the patient has been referred to a specialist.

48. I have also seen a letter dated 22 June 2012 from Dr [I/S] to Liam's GP that references the GP's concerns about the prescription. It therefore appears that there was a professional disagreement about Liam's prescription.

49. I am not in a position to say what, if any, impact these matters relating to his medication had on Liam. But it appears to be another area of his treatment that lacked clarity and certainty, with the patient caught up in a professional debate and unnecessary administrative procedures.

50. As an inpatient, I believe Liam attended group therapy sessions. However, there were significant difficulties in obtaining one-to-one psychological support for him. As noted above, it was only in April 2012 and following formal complaints that Liam started having sessions with the psychologist, Dr [I/S]. In her complaint of 10 April 2012, Liam's mum said this:

"My son has been admitted intermittently into Chelmer Ward since November 2011 where care plans have been agreed on his discharge which have consequently not been followed through due to lack of service providers.

Liam reacts very badly to any stressful situation and needs the services of a psychologist to help him re learn appropriate responses to stressful situations which are common in every day life. Today following yet another care review which I also attended at Chelmer Ward under Dr [I/S] *we were told that there is a one year wait !!!!! for Liam to obtain these services which are essential to him being able to lead a normal life which does not end with a suicide attempt any time things go awry in his life."*

51. When in the community, Liam was supposed to be supported by a CPN, based at the CMHT at Regent Road in Epping. His assigned CPN for most of the 2011-2012 period was [I/S] [I/S] seemed to have a lot of time off sick and was often not available to Liam or didn't do what he said he was going to. For example:

    a. I have seen a note in Liam's records that [I/S] was supposed to attend a meeting with Liam on 25 January 2012 but didn't because he was off sick.

    b. [I/S] was supposed to be present at our meeting with the wider team on 24 April 2012. He didn't attend, for reasons that I can't recall.

    c. In early August 2012 a new resident moved into the Nacro accommodation. I understand that this upset the balance of the house and a number of residents, including Liam, were upset about it. On 2 August, Liam became upset and started breaking crockery and looking as if he would self-harm. As I've explained above, that led to him being temporarily sectioned for his own good for a few hours until he'd calmed down. The following day, on 3 August (a Friday) a member of the Nacro team called the CMHT to discuss Liam's care. [I/S] was not available, but the duty worker agreed to pass the message on and ask [I/S] to call back on Monday (6 August) to arrange a visit. When I raised the issue of CMHT non-responsiveness with the Trust after Liam died, I was told that [I/S] and the duty worker had agreed the message had been passed on, but [I/S] had then failed to call back on 6 August as agreed. I was also told that the issue had been discussed with [I/S] by his manager because this fell below expected Trust standards.

d. On 13 August 2012, Liam became intoxicated early in the day. By all accounts that was unusual for him. It was not his normal pattern, but we'll never know why he did. [I/S] (Liam's caseworker at Nacro) called the CMHT at some time between 16:00 and 17:00 that afternoon because she had concerns about Liam's mental state. [I/S] was off sick and I understand that a message for him to call back "ASAP" was written in a message book. That call was never returned and Liam died the following day.

52. The complaint that Liam submitted alongside his mum's on 10 April 2012 said this about his difficulties accessing support in the community:

> *"I Liam Patrick Brennan 10/8/83. Give full authority to west essex primary care trust to access all my medical records in respect of my complaint regarding my treatment by the mental health team in chelmer ward and also the community mental health team at regent road epping. In particular Dr* [I/S] *and my CPN* [I/S] *who have repeatedly not followed through on my agreed care plans. I have been told I have to wait over a year to see a psychologist which is unacceptable. I have received no support in the community after each time I have been discharged even though it has been agreed in my care plan"*

53. I appreciate that people will sometimes need time off. But when they are responsible for a vulnerable person like Liam, there needs to be a system in place to ensure that someone else can cover for them when they aren't available. It is almost unbelievable that I would have to make this point.

Liam's treatment – addiction

54. Liam struggled with addiction from his teenage years. In later life, he worked in a pressurised environment as a chef in professional kitchens. I think it's generally acknowledged that kitchen shifts are full-on, and it is difficult to wind down or fall asleep when a shift ends. I think alcohol aided that for Liam.

55. As explained above, Liam received support from ADAS. Beyond that, I have seen reference in his medical notes to encouragement that he reduce his drug and alcohol intake, preferably to zero and I know there were rules against drug and alcohol use on the wards and at Nacro. However, there doesn't ever seem to have been any specific addiction-focused treatment, with someone having the time to work Liam out and work on the underlying causes of his use

of drugs and alcohol. It constantly looks like firefighting, with Liam being admitted back into the community as soon as he's stable but without anyone having really engaged with him in a holistic sense.

Liam's discharges and community accommodation

56. Decisions about discharging Liam from inpatient care seemed to be made by the team at the Derwent Centre when they felt he was ready to leave. I didn't ever get the impression from Liam that he felt he had been discharged too early. He always seemed happy to leave. The only time I might have had a concern was the discharge that I was involved in in March 2012 (outlined above at paragraph 18). On balance I formed the judgment that if Liam didn't think being on the ward was doing him any good, then he was better off not being there. My concern was why being on the ward wasn't doing him any good. Upon reflection, this sequence of events would reinforce my view that Liam's underlying mental health conditions could have been treated. On most occasions, a stay in the ward would lead to Liam calming down and stabilising within a short time period. Liam's issue appeared to be needing coping mechanisms to deal with triggers that occurred day to day.

57. I had concerns about Liam's accommodation in Epping. I felt that the group of people there wouldn't be the right influence on each other and that the support they needed wasn't in place. I was pleased when he was given a place at the Nacro accommodation in Harlow, but in hindsight I think there were probably the same problems there. You wonder about the potential consequences of putting a number of vulnerable people together in one place, some with very complex and specific needs. With that said, I know that Liam had a lot of time for his caseworker at Nacro, [I/S]. She showed that she cared, and I remember Liam's mum remarking a number of times that he valued her and that she was a good point of contact for him.

After Liam's death

Initial discussions with the Trust and Nacro

58. Liam's mum phoned me in the early evening of 14 August 2012 to tell me that Liam had died. I was disbelieving and asked "How do you actually know that?". She responded, "because the police are sitting in my living room and have just told me".

59. My daughter remembers going to the funeral director with her Mum the day after Liam died to start to make arrangements. She remembers her Mum advising the director that she had not been told where Liam's body was being held. No one from the trust, Nacro or the police had provided that information. The director made a phone call and was able to advise them that Liam's body was at the mortuary at Princess Alexandra Hospital. Liam's Mum, our son and daughter and I then paid a visit to the mortuary in the late afternoon of 15 August 2012 – the day after Liam died.

60. After a few days, I made contact with the police to try and understand what had happened. Initially they were reluctant to have that conversation with me, but I insisted because I felt that I should be treated as an equal parent. They came to my house and told me about the circumstances of Liam's death.

61. After the funeral, I started picking up correspondence with Nacro and the Trust.

62. With Nacro, the first meeting was a disaster. We met a lady who simply wasn't equipped to have that discussion with us. Some of the things she said and did were plainly inappropriate. She tried to be bright and chatty and totally misjudged what we were there for. I therefore wrote to the Chair of Nacro, who passed the matter on to a Mr [I/S], who I believe was Director of Operations. He adopted an entirely different approach. He demonstrated openness and a willingness to learn lessons. Nacro ended up producing a lengthy report setting out the things that had been learnt and what would change as a result.

63. I found the attitude and approach of the Trust to be different.

64. The overarching theme of my interactions with the Trust in the aftermath of Liam's death was that whatever information I obtained had to be extracted. I am now aware of the duty of candour that exists within the NHS. The exercise of that duty was not in evidence at all.

65. The Trust's 7-day report into Liam's death was completed in August 2012. However, I was not even made aware of it until much later. I cannot recall exactly when, but during a conversation with [I/S] she referenced the report as if I had seen it. I explained to her that I wasn't aware of the report and I think she was a bit taken aback by that. She sent it to me by letter of 13 January 2013, which also confirmed a further meeting for 15 January.

66. The 7-day report made for difficult reading, and I had a number of concerns about it:

a. Firstly, it was littered with initials rather than names, which I feel goes to the point about candour and accountability.

b. Secondly, it revealed the extent to which Liam's diagnosis had been bounced around. I understand that there can be nuances in diagnoses and it may be that some of the expressions of diagnosis actually amount to the same thing. But as a family member, it made me wonder whether the people treating Liam really knew what they were doing or knew what was wrong with him.

c. Thirdly, the report revealed the issue I've discussed above about the disparity between what the CRHT team had prescribed and what the GP had prescribed.

d. Fourthly, the content seemed to be selective and the findings did not resemble the reality that we lived through with Liam's treatment. For example:

    i. There was reference to good quality risk assessments followed by a list of Liam's struggles with substance abuse, arrests and self-harm. The narrative was clear: "we did our best, look at what he was like, no wonder he ended up like he did".

    ii. In the timeline of events, there was no mention of the meetings we had with the Trust in March and April 2012, there was no mention of the complaints that Liam and his mum had submitted, and there was no mention of the unsuccessful calls to the CMHT on 6 August and 13 August.

    iii. There was reference to effective collaborative working across NEPT services. That was not our experience. I don't dispute that there was an intention for collaboration, but it clearly fell down. Inpatient services and community services were not joined up and nor were Nacro services and Trust services. From my standpoint, once Liam was passed from Chelmer ward to the community, there was no follow-up to check that what had been planned for him was actually happening, how it was working and whether it needed to be revised. To my mind, collaborative working would have resulted in something much better than what we saw in Liam's case. Each individual piece of the jigsaw might have been ok, but they simply didn't fit together correctly.

iv. There was reference to care plan tasks being actioned as detailed. Again, that was not our experience and Liam's complaint outlined above bears that out.

v. There was reference to supportive interventions during crises being appropriately identified. I felt that if the Trust had really looked at the circumstances in which Liam died it is patently obvious that interventions were not appropriately identified and actioned during crises. When people tried to obtain support for Liam in the last days of his life the message was either not received or not actioned.

e. Fifthly, the report suggested that Liam had been found dead at around 17:00. That was contrary to Nacro's records, which said he had been found at around 13:30. In a letter from the trust dated 6 February 2013 addressing this specific point it was explained that the report recorded that Liam was found dead at 17.00 (which was incorrect) but that was not being held out as the time of death. It also said the purpose of the investigation process is to clarify circumstances leading up to a death, referencing the role of the police and the coroner's department to ascertain how and when death occurred. If referencing a time at all, the author should have got the time right. Not doing so undermines other 'factual' comments in the report.

f. Sixthly, the report made a completely speculative conclusion about whether or not Liam intended to end his life before any report from the toxicologist or coroner had been produced.

g. Finally, I was shocked by the narrowness of the recommendations that were made. It was noted that a large volume of records were missing from Liam's file and some documents had been filed upside down. The only recommendation made was that the current paper records system would benefit from review. My feeling when reading that was that a 29-year-old man had died in their care and all they can say is that some papers were filed upside down.

67. If the Trust was serious about adopting a culture of learning lessons, I would have hoped that this report would put front and centre the question: what can we learn from the death of this young man? But that wasn't the case. It seemed to me more of a tick-box exercise so that if anyone asked about Liam's death, the Trust could say they've looked into it.

68. Having received a copy of the 7-day report, I then engaged in further correspondence and discussions with the Trust. On 15 January 2013, I attended a meeting with [I/S] and Dr [I/S] We discussed my concerns about Liam's care and the 7-day report, but I didn't feel that they were fully addressed. I therefore followed-up by email, outlining the issues that I felt remained outstanding. I received a letter in response from [I/S], dated 6 February 2013. It was that letter that addressed the points about the change of protocol so that medication faxes are followed up by telephone and about [I/S] failing to follow up on the 6 August call (discussed above at paragraphs 47 and 51c respectively).

Liam's Inquest

69. On 19 February 2013, Liam's Inquest was held at Chelmsford Coroner's Court before Mrs Caroline Beasley-Murray. In advance of the Inquest, Liam's mum received a request from the Coroner's Office for a statement about Liam and the circumstances of his death. She and I prepared that together and provided it from both of us.

70. From the outset of the Inquest, the Coroner made clear that her remit was very narrow. She explained that her role was simply to answer a few narrow questions about how Liam died. I understand that a Coroner's role is limited, but I have also read about other Inquests where the Coroner seems to have made specific findings and requested that further actions be undertaken. It was clear to me that Mrs Beasley-Murray wasn't interested in doing that in this case.

71. The Trust was represented at the Inquest by the Area Director for West Essex, [I/S] [I/S] and [I/S] was also present. Ms [I/S] explained that [I/S] (who we had met with previously and had been involved in the meeting of 24 April (see paragraph 21 above)) was due to attend for the Trust but couldn't because she was on holiday. At one point Ms [I/S] stumbled over Liam's name and I had to remind her of it. I appreciate that she was asked to step-in and perhaps wasn't familiar with the file, but that only contributed to the feeling that this wasn't a matter that was being taken seriously by the Trust. I think if [I/S] couldn't be there, they should have delayed until she was available.

72. The Coroner asked me some questions about Liam's death and the aftermath. I explained that we had found the Trust to be defensive and not transparent in their communications with us. I said to the Coroner that based on my experiences with the Trust, my overriding feeling was that there are likely to be many more cases like Liam's coming before her. I thought that the

outlook for families in a similar position to ours would be hopeless (literally without hope) and therefore the outcome would be the same.

73. The Coroner then asked some questions of Ms [I/S] who clearly wanted to focus on the outcomes of the 7-day report. I felt that she was there to say the minimum and try and get though the hearing without any damage to the Trust's reputation. In that sense, it was a highly defensive approach. I also felt that the Coroner did not push her sufficiently on certain points and I therefore felt the need to speak up more forcefully. For example, on the point about the Trust failing to respond to the phone calls that were made on 6 and 13 August. I also raised my concern about the fact that the only recommendation made in the 7-day report was in relation to some documents being scanned upside down. Ms [I/S] response was that that was actually a very important issue for the Trust.

74. I had never been to an Inquest before and there was never any guidance or support offered about the process from either the Trust or the Coroner's office. In retrospect, I feel let down by the Inquest. I was hoping that it would be an opportunity for meaningful reflection and lesson learning, but that is not how it felt. The Coroner encouraged us to continue discussions with the Trust about our concerns, but from my perspective she had heard about systemic issues (for example, urgent calls for help being recorded in a book and going unanswered) and was either unwilling or unable to take any steps to have them addressed. By asking us to keep talking, it felt as though she was saying to the Trust "keep a dialogue open, but that's enough, nothing really needs to change". The Coroner's office must have been aware of the number of inquests they were having to conduct into the deaths of those who died in the care of the Trust, yet I had the sense that our case was an isolated one. The setting up of the Lampard Inquiry is evidence alone that this was not true, and the Coroner's Court should have started 'joining the dots'.

75. The Coroner did not feel able to make any significant findings or recommendations. She recorded an open verdict with the cause of death being mixed drug overdose.

Further discussions with the Trust

76. The Coroner had encouraged us to continue talking to the Trust about our concerns and that is what I did. I wrote to the Chief Executive, Andrew Geldard, copying the non-executive directors, to set out the issues that I felt remained outstanding. Those were as follows:

a. I was concerned that I had still not been given access to Liam's file, despite a formal request one month earlier.

b. I asked that the Trust acknowledge that calls for help had gone unanswered and that even one ignored call from a person with mental health issues was too many. I suggested that the Trust's defensiveness on this point was unseemly and distressing for the family.

c. I asked that there be accountability for the lack of support provided to Liam by the CMHT and his CPN.

d. I asked that the Trust follow Nacro's example and use this tragic event as an opportunity to examine how services could be improved for patients and families.

e. I asked for reassurance that future 7-day reports would be thoroughly prepared with care, understanding and with a view to learning as well as the accurate recording of events.

f. I raised concerns about the fact that the meeting we attended with the Trust on 24 April 2012 was not referred to in the 7-day report and that apparently the reason for that was because the meeting took place as a result of a complaint. I observed that the effect of this policy was to deny a family a full and frank investigation and report because they had the temerity to complain.

77. I requested a meeting with Mr Geldard to discuss my concerns.

78. Mr Geldard responded to acknowledge my letter and then followed up with a further letter a few days later. He explained that he had set up a meeting for me with [I/S] (Director of Operations and Nursing) and [I/S] I attended that meeting with my daughter on 8 April 2013.

79. There was clearly tension in the room when we arrived, as if they felt it would be a difficult meeting. I had an agenda of the points I wanted to discuss, but the first thing I explained, because of the tension, was that we weren't there with a view to establishing blame or making a financial claim against the Trust. We were there to try and ensure that some lessons were learned. [I/S]s body language visibly changed after that, which told me that what they feared most was managing the Trust's liability. It was also revealing that towards

the end of the meeting Ms [I/S] said that she had heard on the radio that someone local had taken their life and she "just hoped it wasn't one of ours". That seemed to me an odd thing to say, but with the passing of time and seeing what's happened at the Trust, it now suggests to me that they knew there were wider problems.

80. We went through the points I had outlined in my letter to Andrew Geldard. When we discussed the unanswered phone calls, [I/S] explained her view that if the word "urgent" had been used it might have prompted a different response and that there was a Duty Officer on call who might have been able to assist. We talked about the fact that none of this featured in the 7-day report and she explained that the person who prepared the report had not had this information or even been aware of the book in which messages were recorded. This was all ground that we had gone over at the Inquest. The tone of our meeting was that the trust was as engaged in corporate defensiveness as it had been at the Inquest. For example, hiding behind the fact that the word 'urgent' had not been used in the call from Nacro to the helpline. Surely the relationship between Nacro and the Trust was one whereby Nacro would have only called the helpline when help was needed that only the Trust could give?

81. I was professionally unimpressed by the Trust representatives at that meeting. I don't feel that anyone had bad intentions but just that they lacked the gravitas to deal with something like this. At the end of the meeting, I asked that any follow-up correspondence be with Andrew Geldard. I received a further letter from Mr Geldard dated 10 April 2013 that responded to each of the points of concern I had raised.

82. I can't say that I felt satisfied with the way the Trust had engaged following Liam's death. It was characterised by defensiveness throughout. In so many instances, through all walks of life, we see that the apparent attempt at concealment is far more hurtful than the underlying mistakes that may have been made. In the interests of balance, and as hard as it is to live with, I accept that as a parent I didn't keep Liam safe. Liam didn't keep himself safe. This is a collective tragedy. I can't and won't hide my part in it and Liam wouldn't hide his part in it. So why should the Trust hide theirs?

83. I started out needing to try to understand exactly what had happened to Liam and what had gone wrong. I think that was part of my coping mechanism. But after more than six months of painstakingly trying to elicit information, I got to the point where I had to ask myself "am I getting any benefit from pushing further?". I have watched how people affected by other

tragedies have fought for years and years to get to the truth and it has ended up destroying them as individuals. I reached the point of recognising that if I was going to have to work this hard to get at more of the truth it wasn't going to do me or my family any good. So, I decided to stop pushing. That is a source of shame for me, but I now have the opportunity to put that right through this Inquiry. I hope that the Inquiry can get at things that I couldn't. Not only about Liam's individual case, but about what happens and doesn't happen behind the scenes.

Conclusion and recommendations

84. The 7-day report may have given the impression that Liam's death was inevitable, but I don't think that was the case. I return to a point I made at the outset: there were significant periods of time in Liam's life when he was happy and well. When he was under the care of mental health services in Essex, to the untrained eye, I thought "this cannot be the most difficult case they've got on their books". If he was always out on the streets, always drunk, always on drugs or in trouble, I might think "where's the hope here?". But his moods did fluctuate and when he was good, he was very good. So, to my mind, there must have been a way of capturing those moments and giving him the coping mechanisms that he needed to deal with the difficult times. Liam didn't know what worked for him in those times. All he knew was that he wanted to be happy and he wasn't able to create that happiness for himself. That is where we needed the professionals to step in.

85. We read of people who go through the most appalling trauma and somehow, with the right support, they are able to get their lives back on track. But not Liam, someone who sometimes found himself in a black hole that he couldn't get himself out of. To my mind, in the 21st century, we must have got to a place where we can find solutions for that.

86. I realise that any recommendations I make come from a lay perspective. I am obviously not a clinician, but what I am able to draw on is some clear organisational imperatives, tempered, I hope, with some understanding from having been a Trustee in several organisations that are not profit-oriented. The recommendations I would like to make are as follows:

    a. **Mental health equivalency** – The starting point is that mental health needs to be viewed and treated as the absolute equal of physical health.

    b. **Patient-centred service** – This recommendation is about creating a patient-centred service. In my view, what would make the NHS genuinely patient-centred would be

the adoption of a principle that there is one patient, one plan, one accountable clinician and one agreed set of desired outcomes. It is a thread that would run through any and every interaction with that patient. The only thing that matters is getting them to a better place than they are in at the outset. Everyone involved with that case knows what the desired set of outcomes are and, even though there are lots of other people helping to deliver them, there is one person and their deputy who are ultimately accountable. That is not to design a system around knowing who to blame. It's about ensuring a clear line of sight for responsibility, for clarity of judgment and for drawing the whole care plan together, so hopefully people are looked after better. It is about making sure that a care plan doesn't get diluted just because lots of people are involved in delivering it.

c. **Non-judgmental approach** – Mental health issues are not the fault of the patient. Sometimes a patient's lifestyle may not help, but the starting point has to be from a non-judgmental perspective. There was always a sense of judgment towards Liam and that is carried through into the tone of the 7-day report. That is a cultural issue that needs to be addressed. If I break my leg because I've been out drinking and I slip on some ice, I will be taken to A&E and while a nurse or doctor might think "what a fool", they will deal with me as they find me and treat my injury. While I'm going through that, once I'm in their hands, I will immediately have the hope and expectation that my leg is going to be repaired. At no point through the process did I feel the equivalent for Liam, that he was accepted for who he was and what he was dealing with. Mental health services need to accept that they are dealing with what is in front of them, in the same way that physical health services do. Alongside that is the issue of the extent to which a mental health patient can be expected to drive their own recovery. I accept that, as with physical health, recovery is a collaborative effort. However, what came across strongly in my meetings with NEPT was the professionals putting the onus back on the patient and I think that is wrong.

d. **Duty of candour and lesson learning** – This recommendation is about dismantling the culture of defensiveness. Mistakes happen, unfortunately even fatal ones. Every organisation should want to learn from them. I said in my letter to Andrew Geldard that it was hard to imagine how Liam's death could have been made any worse, but the Trust managed that in its approach to the investigations and engagement that followed it. There is clearly a fear of liability in the NHS, but if the effort that was put

into liability management was instead focussed on improving the organisation that could only be a good thing. The NHS should genuinely embrace the duty of candour not display it as a cultural value that exists for PR purposes only.

e. **Communicate clearly and abandon jargon** – Mental health issues are complicated enough as it is, in my view the use of plain English in this area is key to everyone understanding what the issues are. A child will tell you the truth and they will tell you in such a way that it is perfectly clear what they think. We then spend our adult lives ditching all of that clarity and developing a language that isn't at all transparent. Some people, I'm afraid, then use that language deliberately. hiding behind euphemism and business-speak. The use of acronyms makes things harder to understand. Phrases like 'service user' are dehumanising – patients regard themselves as patients; it is called the 'Outpatients Unit', why don't we just use the word 'patient'? Job titles like 'Making Experiences Count Manager' are utterly meaningless and just arouse cynicism.

f. **Apologise properly** – If an NHS Trust is going to apologise for something it should do so properly and understand what it is apologising for. Again, simplicity and clarity of language is important and the best phrase is "I am sorry", rather than "I apologise if…".

g. **Ensure external agencies are fit for purpose** – I understand that outsourcing of certain services may be necessary. But if that is happening, the Trust must ensure that they are adequately funded, that they are well managed, that the right calibre of people are in place and that any accommodation is appropriate. I would question what added value Nacro was bringing to Liam's care that the NHS, if it had the funding that Nacro had, couldn't deliver itself.

h. **Invest in technology** – We hear about how much money is being spent in the NHS, but then it is still sending out hard copy letters, communicating by fax, recording messages in handwritten books and not examining all the facts in the aftermath of a serious incident because files are incomplete or services are not joined up. Investing in technology could improve the way the NHS communicates with patients, families, carers or agencies, and help investigate issues, learn lessons and disseminate that learning.

i. **Leadership and professionalism** – People in leadership roles need to ensure that everyone who touches a patient's care pathway is qualified, professional and committed to the patient and their care. That goes beyond just having some letters after their name. It's about ensuring that people are empathetic and genuinely want to work in that area of medicine.

j. **Treat family members equally** – Where relevant and appropriate, Trusts should treat family members equally. There were various times in my engagement with NEPT when I was not treated as the equal of Liam's mother. For example, correspondence would be sent to her and I had to rely on her forwarding it to me. When Liam died, his mother was offered emotional support, but I was not. We both suffered the loss of our son, but only one parent was deemed worthy of support. I accept that it may not always be appropriate or possible to engage with two separated parents. I am not suggesting that parents need to be tracked down in every circumstance. However, in this instance it was patently obvious to the professionals involved in Liam's case that both parents were involved, both parents had visited him and both parents had attended meetings. It shouldn't be assumed that only one of them cares or is grieving.

k. **Inquests** – When a Trust is engaged with an Inquest, it should ensure that it puts forward a representative who knows the case. I also think that Coroners should have more power to acknowledge and address the issues that they hear about. Sticking to a narrow remit, as we saw at Liam's Inquest, means that Coroners are more likely to hear recurring issues.

87. In my Commemorative Statement to the Inquiry, I said that whatever the outcome of the Inquiry, nothing will take away the feeling that I have failed Liam. My purpose in being involved in this Inquiry is not through a sense of wanting to seek any form of arbitrary 'justice' for Liam because that is not what the Inquiry is about and, in any event, nothing the Inquiry says or does will bring Liam back. I am only interested in contributing to a list of recommendations that will hopefully improve the quality of care for future patients with mental ill-health. On 10 April 2013 I received a letter from Andrew Geldhard, CEO of the Trust at the time, expressing his condolences and apologies for those occasions where the expectations of our family were not met by the Trust. In light of the need for this Inquiry these condolences and apologies are meaningless. I can only hope that whatever organisation is charged with the responsibility of delivering mental health care in the future will hold a

genuine desire to learn and act upon all the lessons and recommendations the Chair may make and I thank the Inquiry team for all they are doing to achieve this outcome.

I believe the facts stated in this witness statement are true.

Signed [I/S]

Date: 4th June 2025