IN THE LAMPARD INQUIRY

Witness Name: Karon Pimm
Statement No: 1
Exhibits: Nil
Dated: 4 June 2025

FIRST WITNESS STATEMENT OF KARON PIMM

I provide this statement in response to a Request under Rule 9 of the Inquiry Rules 2006 dated 24 February 2025 and will say as follows:

Introduction

1. My name is Karon Pimm. I am the mother of Terence Jospeh Pimm, deceased, known as 'TJ', who was born on 25 November 1985. I live in Essex and my address is known to the Inquiry.

2. I used to work as a full-time registered nurse in the urology ward at Colchester General Hospital. My husband (Terry Senior) used to be a black cab driver, however, since TJ's death he has been unable to work, due to the significant impact it has had on him. I have also since retired.

3. We also have two daughters: Charlotte Wood and **[I/S]** TJ was our middle child. We were always a close family. The loss of TJ has affected us all so deeply, more than I can even put into words.

4. TJ was 30 years old when he died on 26 August 2016 after jumping from the **[I/S]** of a carpark in Colchester. This followed his contact, the day before, with the A&E Psychiatric Liaison Services at Colchester General Hospital (run at the time by North Essex Partnership University NHS Foundation Trust ("NEPT")) who, despite his suicidal state, refused to assess TJ and discharged him without any support plan or safeguards in place.

5. I spoke about TJ at the commemorative hearings in September 2024 and provided detailed information then about his life and family background. I will not repeat those details in this statement, the focus of which is on the standard of care that TJ received from the Essex Trusts, and how, in my opinion, the way he was treated left him feeling alone, scared and vulnerable to such an extent that he felt he had no choice but to take his own life.

Diagnosis

6. As I set out in further detail below, neither myself nor any other family members were involved in TJ's mental health treatment or care. The GP never asked us for any information and TJ never discussed the details with us. In order to be able to answer some of the questions asked of me by the Inquiry, my legal team has reviewed and informed me of the content of a number of documents, including GP records, hospital records, inquest hearing notes and experts' reports. I will refer to these documents where relevant in order to best assist the Inquiry in providing as much information as possible about TJ's involvement with the Essex Trusts.

7. When TJ was around 17-19 years old, he went to America twice to do football coaching. He was a very good footballer, and when he was 14, he went to Colchester football club, where he got his coaching badges. He seemed quite happy at this point and generally okay in his early adult years, however, I think he tried to hide how he was truly feeling to us, as I am now aware that the GP records show that TJ first reported mental health problems to his GP in June 2004. The notes record that he suffered from a first presentation of "*anxiety with depression*".

8. The GP records indicate that, on 30 March 2006, TJ was prescribed a sedative, after he presented with "*nervous tension worries about everything*". I note that there is a further entry in the GP records, on 5 May 2006, referring to TJ suffering from nervous tension, reporting that he was not sleeping, tearful and anxious. It appears he was signed off work for a period after this in mid-2006.

9. I was not aware of these struggles that TJ was experiencing at the time. The first time I became aware of TJ seeking support from his GP for any form of psychological problems was when he moved to London, which I will address later in my statement.

10. Looking back, I knew that ever since TJ was a little boy he had, at times, found it hard to deal with day-to-day life. His sister Charlotte has described him in the past as being

quite mentally fragile, and I think he might have had undiagnosed bipolar disorder. Although we knew he was sensitive, TJ always tried to hide things that were troubling him from our family as he did not want us to worry about him. TJ also had obsessive compulsive traits and always had to have everything neat and ordered.

11. We as a family were aware of TJ's long-standing issues with alcohol. From early adulthood, he had always liked a drink. There was an incident in 2007 where TJ got a new nice car and had only had it for a week, before he was pulled over for drunk driving. Looking back, we think this was a key incident that marked the beginning of his issues with alcohol.

12. TJ moved to Manchester in roughly 2007/2008 and lived there for approximately 3 years. TJ had one son, [R/O], with his then partner. They lived together in Manchester for a short period; I am not sure for how long exactly. My husband Terry and I used to drive up and down to babysit [R/O] and often would stay a few days as it was quite far away. I do not think TJ had any drug issues at this point and his mental health to us seemed okay. The main issue that we noticed was his drinking. This caused problems with his partner, as TJ would like to go out and party, whilst she was left caring for the baby, which would then result in arguments.

13. There is an entry in the GP records dated 15 March 2010 that refers to TJ having domestic difficulties and presenting with anxiety and depression. The note records that TJ reported taking an overdose of approximately [I/S] paracetamol several weeks before. I was not aware of this incident at the time: neither TJ nor his GP informed me of this. I wish I had known so I could have provided TJ with the support and reassurance he plainly needed from this early stage.

14. By the following month, April 2010, TJ was living with us in Dovercourt, near Harwich in Essex, on a temporary basis due to increasing problems with his partner. I know that during this time he was really worried about letting his son down. He really wanted to get better and to return to his family; that was always his hope. I am aware that there are several entries in the GP records in April 2010 concerning TJ being signed off work for stress and anxiety in this period.

15. Sadly, by May 2010 the relationship had definitely finished. Due to an incident where TJ turned up drunk to pick up **his son, TJ did not see his son** for a period of time, which was a source of significant distress for TJ. It was around this time that I recall TJ started to drink more heavily. It is recorded in the corresponding

GP entry for 6 May 2010 that TJ was committed to his son and that this was identified as a protective factor against suicide in the context of his relationship breakdown. There is also reference to TJ having contacted Rethink - which I understand was the North East Essex IAPT service - to arrange a session. The records however indicate that TJ was subsequently discharged from the IAPT service, without ever having been assessed. It also appears that he was signed off from work again in early May 2010, though I was unaware of this at the time.

16. As far as I can see, there are no further relevant GP entries until January 2012, where there is reference to TJ presenting on 18 January 2012 with stomach pains. The entry records that he was drinking heavily at this stage, of up to 75 units of alcohol a week. The same entry refers to TJ suffering from anxiety and using recreational cocaine. It was around this time that I became aware that he started to access support for his mental health.

17. In a further GP entry, on 24 January 2012, TJ was noted as having anxiety with depression, reporting that his symptoms had worsened since his break-up, and that he suffered from low mood and frequent thoughts of self-harm. The records refer to TJ being prescribed Citalopram, on his request, which is an antidepressant, which I was aware of at the time. TJ's GP also re-referred him to Rethink at this stage, however in February 2012 the service summarily discharged him, on the basis that his main problem appeared to be alcohol abuse. TJ was provided signposting details for alternative alcohol support services, including NEEDAS (North East Essex Drug and Alcohol Services) and Open Road.

18. By this time, in 2012, TJ was working in London in a good job as a business rates advisor. Although he seemed to enjoy his job, he was very stressed and there was a bad culture of drinking and drugs in his workplace, which is when I think drugs first likely became an issue for him. I believe that TJ also started to develop real problems with alcohol at around this time, which grew worse over the following years and seemed to have contributed to his declining mental health. His restricted contact with his son throughout this period, whom he missed terribly, also greatly affected him.

19. Whilst I was aware that TJ was struggling with increasing low mood, I wasn't aware of the full extent of his mental health issues, as he didn't open up to us about this. He would often try to mask how he was feeling to us and put a brave face on things. I note there is reference in the GP records to an incident on 16 February 2012 when the police contacted the GP surgery looking for TJ after he had gone missing. TJ

subsequently reported to the GP, in a review on 2 March 2012, that he had been drinking on this occasion and took an *"impulsive"* overdose of his antidepressant medication which he later regretted. The police were then called when TJ failed to show up for work. I was made aware of the overdose at the time, which really shocked me. This was a clear marker to me of how serious TJ's mental health issues were becoming, even though he would not speak to us about them.

20. Following this episode, in March 2012, TJ quit his job in London and came back to live with us in Essex. I can't quite remember for how long he stayed with me for, as it was so long ago. He was out of work for some time.

21. During the Spring of 2012, TJ did become increasingly reliant upon alcohol, which I believe he used to manage his anxiety. He started to drink more and more, and by November 2012, I noticed that TJ's low mood seemed to be more sustained. I am aware that the GP records refer, in this period, to TJ beginning to have frequent thoughts of suicide, including jumping from a train. TJ never talked to us about these thoughts. The GP records refer to him drinking heavily in this period and being sent back from work as he was not in a fit state to work. The GP made a referral to the local mental health crisis team on 20 November 2012, due to concerns over TJ's suicidal ideation. It appears however that this referral was subsequently declined by NEPT Community Mental Health Team, on the basis that TJ was already open to Rethink and Open Road, so the service could not assess him.

22. By December 2012, TJ did seem to appear brighter in himself. GP entries from this period refer to TJ still suffering with low mood and intermittent suicidal ideation, however showing some recent improvement, including trying to live a more healthy lifestyle. In a GP review on 20 December 2012, I note that TJ himself requested to be re-started on anti-depressants, leading to him being re-prescribed Citalopram. The medical records also indicate that TJ attended, in December 2012, a triage assessment with Rethink, which identified his main problem as depression. It is recorded that TJ agreed to attend further sessions with a 'psychological wellbeing practitioner', though n such sessions are subsequently recorded.

23. I cannot be sure of the exact dates, but I think it was in around 2012-2014 during which TJ worked a number of different jobs which resulted in him living in various different places. I don't now remember all the details, except that at one point he had a job in Chelmsford in advertising. TJ then got a job at British Telecom and, in roughly 2014, he met his new girlfriend **[I/S]** I cannot remember when exactly, but

eventually they moved in together. TJ was seeing his son a little during this time, and I remember they had a bedroom in their flat for him so he could come and stay. However, I know there were still periods where **he did not have contact with his son [I/S]** which inevitably impacted his mood.

24. During this time, I know that TJ was continuing to drink heavily. He kept getting payday loans to buy alcohol, which his girlfriend would have to then pay off for him. I know he was also sometimes stealing wine from his local Tesco or not turning up for work. It seemed to us that TJ was entering an increasingly self-destructive pattern of drinking to escape his problems.

25. In Spring 2015 TJ managed to abstain from alcohol for a short period. However, by August 2015, he had started drinking again. The medical records indicate that he saw his GP in Hertfordshire (where he was living at the time with his girlfriend), about this, who assessed him as presenting with Alcohol Dependence Syndrome. TJ self-reported he was drinking 70 units a week and requested professional help. In a further GP review in October 2015, I note that TJ was re-started on Citalopram, at his request, after he reported feeling low and depressed. He was also referred to the local South East Hertfordshire Wellbeing Team, after requesting counselling, though appears to have been discharged soon after, without initial assessment, as he failed to engage.

26. In December 2015, I eventually had to pick up TJ from his girlfriend's flat, following an altercation between them. TJ was by this point in a cycle of getting into debt, gambling, drinking, and taking drugs. His girlfriend [I/S] had clearly had enough and could not deal with him anymore and therefore wanted him out of the house. They had a big argument, during which TJ smashed a phone on the floor. I was there and I witnessed this. His girlfiend ended the relationship for good, and TJ returned home to Essex to live with us. After this, TJ started sending his girlfriend lots of messages.

27. Following this, TJ was charged with assault. This related to the incident, described above, when TJ threw the phone; he did not physically assault his girlfriend. TJ pleaded guilty and was sentenced in February 2016 to a Community Order and was also made subject to a restraining order due to the messages he sent. This was a very sad and upsetting time for all of us as a family, as TJ and his girlfriend had been due to get married in March 2016. We had already bought bridesmaid dresses, booked a venue and everything.

28. In March 2016, TJ was started by his GP on a different antidepressant, Sertraline, as well as a sedative, Zopiclone. From recollection, I think TJ only took his tablets for about a month. The same GP entry also refers to TJ having started to attend Open Road, a local drug and alcohol recovery service in Essex, though there is no further indication in the records that he in fact engaged with this service.

29. As a family we started to notice a concerning decline in TJ's mental state during this period. TJ's mood became more up and down. It seemed clear to us that at times TJ was very depressed, but that he wanted to try to appear ok in front of us. He still wanted to be the life and soul of the party, even when he was suffering so much inside. He had got a new job at Direct Line in March 2016, however by about May 2016, he could not face going to work and was signed off work for stress-related illness, before leaving altogether. There were times in this period when Terry and I felt that we could not leave TJ at home alone as were so worried about him.

30. By July 2016, TJ seemed to me to become increasingly low. I note that the corresponding GP records from July 2016 refer to TJ being frustrated by not being able to undertake talking therapies straight away, which he was still on the waiting list for. Instead, he was simply given the referral details, again for the local drug and alcohol services and crisis team.

31. I was not aware that TJ wanted or was trying to access therapy at this time. He often did not tell me about what he was going through or would minimise how serious things were. However, I know now that he wanted help and yet, despite expressly asking for it on several occasions, the GP would just leave him to get on with things and fail to make, or follow-up, the necessary referrals. On the few occasions where a referral was made for counselling, or to the community mental health team, it appears TJ was discharged nearly straight away back to the GP without any proper assessment having taken place. It is therefore my understanding that TJ never in fact received any form of therapeutic support, or intervention from secondary mental health services, before the events of August 2016. I still do not understand why the GP was not more proactive in seeking to get TJ the mental health support he clearly needed, or in seeking to involve us as his family who knew him best.

Assessment/attempts to have TJ assessed in August 2016:

32. I set out below the events concerning and leading to TJ's first point of contact with psychiatric services on 8-9 August 2016. I have included information from my

daughter, Charlotte Wood, as she was involved throughout, and provided a statement for the inquest proceedings detailing what happened.

33. In her statement provided for TJ's inquest, Charlotte explained that TJ stayed at her house the night of 7 August 2016. He had been arrested earlier that day for breaching his restraining order, before being bailed from a police station in London. On arrival at her house, Charlotte recalls that TJ appeared drunk. He slept on a mattress on her bedroom floor. TJ left the house early the following morning, on 8 August 2016. Charlotte was worried about him as he seemed out of sorts. She noticed bottles of lager were missing from her fridge. She explained that about 4.00 pm that day she got a call from TJ's then girlfriend, **[I/S]**, who was hysterical. His girlfriend told Charlotte that TJ was at **a** train station really drunk and threatening to throw himself in front of a train. His girlfriend explained that she had spoken to the station staff and they reported that TJ was very upset. His girlfriend asked Charlotte to go and pick him up from the station.

34. Charlotte had her children with her and so could not go to the station. She therefore telephoned **the** station and spoke with a member of the station staff, who told her that TJ did not seem well mentally and was really upset but they had given him a cup of tea. Charlotte asked the station staff to put TJ in a cab to her house.

35. Around 45 minutes later, staff from the train station arrived at Charlotte's house with TJ. They explained that they had walked him there because they thought it would be a good idea for him to get some fresh air. Charlotte told us after that the station staff were lovely and were clearly going out of their way to try and help TJ. Charlotte recalls TJ appearing very distressed and intoxicated on his arrival.

36. Charlotte then explained that about 20 minutes later, three officers from the British Transport Police ('BTP') arrived at her house. They informed her that the railway staff are legally bound to inform the British Transport Police when someone is encountered as suicidal at a train station. One of the BTP officers was angry with the railway staff for having removed TJ from the train station. They explained that TJ was a risk to both himself and others and should not have been removed from the station, a public area, to a private residence.

37. The BTP officers said that they needed to speak to TJ. He was in Charlotte's living room. The officers were nice with him and spoke to him very calmly but TJ did not want to talk. The BTP officers spoke with Charlotte instead but she cannot recall

exactly what was said to them. However, for the purpose of the inquest proceedings, Charlotte read the statements of the BTP officers, which confirmed that she told them that TJ needed help, and that he would not be forthcoming about his mental health and would likely downplay how he was feeling. Charlotte wanted the officers to know how seriously TJ needed help.

38. Witness evidence provided by the BTP officers to the inquest also confirmed that an officer, **[I/S]**, spoke with TJ directly. TJ stated he could not remember the earlier events that day, but that he needed help for his mental health and had recently seen a GP about his suicidal ideation. The officer recalled he was in a "*desperate*" state, and was anxious to seek assistance.

39. A short while after this, some paramedics arrived. Charlotte could not remember who telephoned them but thinks it was the BTP, which was confirmed by the records subsequently provided to the inquest. The paramedics were really nice, but it was overwhelming for TJ to have so many people around him. He was in such a state.

40. Charlotte gave the paramedics a brief rundown of what had happened.She explained in detail that TJ would minimise his symptoms and that they must not be "fooled" by what he was saying. She spoke to a tall paramedic with a beard who said that they would do what they could, but that it sounded like TJ needed to be sectioned for a 72 hour assessment. The BTP officers also talked to the paramedics about TJ's condition.

41. The paramedic subsequently told Charlotte that they had sourced TJ a place at Goodmayes Hospital and would take him there by ambulance. Charlotte was very relieved by this news.

42. In terms of my direct involvement, on 8 August 2016 I received a telephone call from the transport police whilst they were at **a** train station. They told me that TJ was at the station threatening to commit suicide. Charlotte also rang me to tell me what had happened. I drove to **the** train station but TJ had already been taken to Charlotte's house. When I arrived at Charlotte's, TJ was sitting outside in the back of an ambulance.

43. Charlotte told me that TJ was going to be sectioned for his mental health problems. Like Charlotte, I was so relieved. I rang Terry and said "*put your hands together, they*

are going to section him for 72 hours". By this point, it was all that our family wanted because we did not know how else to help TJ. He seemed so unwell, but he never wanted us to worry about him and would not properly open up about his struggles. If he was admitted to hospital, we hoped he would finally get the help he so sorely needed.

44. I understand that TJ was subsequently detained by the police under s.136 of the Mental Health Act 1983 ('MHA 1983'). He was taken initially to Goodmayes Hospital, in order to undergo a mental health assessment. Goodmayes Hopsital was run at the time by North East London NHS Foundation Trust ('NELFT'). However, before he could be assessed, TJ was then transferred to the Harbour Suite, at The Lakes Mental Health Unit, which was run at the time by NEPT. The Lakes Unit is located next door to Colchester General Hospital, where I worked at the time. I believe TJ was just taken in a cab when he was transferred between the two hospital sites.

45. I think the reason for the transfer may have been because TJ was out of the area of Goodmayes, however I do not know for certain and this was never explained to us. No clinical records concerning TJ's short admission to Goodmayes, or the reasons for his transfer, were provided within the inquest process. As TJ had been brought in by the police, under their emergency powers of detention, in order to facilitate his urgent assessment, I struggle to understand why TJ did not undergo a full mental health assesment at Goodmayes.

46. After TJ was transferred, I kept telephoning the Harbour Suite at The Lakes Unit from about midnight onwards, on 9 August 2016, to ask what was happening. The staff member I spoke to at The Lakes Unit told me that they were waiting for someone to assess TJ. Each time I phoned I told them that I wanted to talk to the doctor who was assessing TJ in advance, because TJ would hoodwink them. I made it clear that TJ would not be honest and that he would make out that everything was fine when it clearly was not. I wanted staff to tell the assessing clinician this because I believed it was really important for them to know. I begged staff to make sure the doctor telephoned me back before assessing TJ.

47. I went to work at about 8.00 am on the morning of 9 August 2016 at Colchester General Hospital. The Lakes Unit was only about 50 yards from the main entrance of the building in which I worked. I rang The Lakes Unit again while I was on my shift and asked to speak to the doctors who were treating TJ.

48. I spoke with a male staff member who told me that they were still waiting for TJ to be assessed by a psychiatrist. I said that I worked as a nurse on the same plot and that I woud come across to the unit because I needed to speak to whoever was treating TJ. The person I spoke to kept saying "*he's 30 years old*". I asked for the assessing doctor to ring me back, but no one returned my calls.

49. I also spoke to TJ while he was at The Lakes, who called me and told me that he was still waiting to be assessed. Not too long after, hospital reception staff telephoned me and told me that TJ was downstairs in reception waiting for me to go home. This was at lunchtime. I was shocked because we had been told it woud be a 72 hour detention, but instead he had been let out of hospital 12 hours later. I finished my work and went downstairs to get TJ. He told me that he had been seen by various mental health professionals, who had all said he was fine. I could not believe it.

50. The clinical records concerning this assessment confirm that it was carried out by Dr [I/S] a consultant psychiatrist, and Nurse **[I/S]**, who was an Approved Mental Health Professional ('AMPH'). TJ was recorded as presenting as "*forthcoming and insightful*", who "*made plain that he is not mentally ill*". TJ's presenting problems were assessed as "*entirely alcohol related*", with no evidence of mental illness or risk to self. The recorded outcome was for 'No Further Action' to be taken, with TJ discharged from s.136 detention with "*no plans for follow up from (mental health) services)*" and with TJ required to make his own treatment plans concerning his alcohol misuse.

51. TJ was consequently discharged without any paperwork. I do not recall that he received any follow-up support from his GP in respect of these events, or from secondary mental health services. He told me that he had been informed that hospital staff were going to arrange for someone to visit him, but nothing was organised. As I have set out above, the underlying clinical records confirm that no form of support plan or signposting was deemed necessary on TJ's discharge.

52. From the information I have since been made aware of, through the clinical records and inquest witness evidence, it appears that the assessing staff simply took TJ's assurances that he was fine at face value. From what I can see, there does not appear to have been any meaningful attempt to explore or assess the triggers for his recent suicidal behaviour. I was particularly shocked that, despite my repeated calls to the unit, TJ had been assessed without the clinical team seeking my involvement or even informing me that it was taking place. As the staff knew, I was just minutes

away and wanted to provide important contextual information about TJ's presentation and history.

53. TJ came back to stay with Terry and me. The following week, I called TJ's GP service in Essex to notify them of these events, as The Lakes had not sent them a discharge summary. Despite my informing the GP of TJ's suicidal state on 8 August 2016, leading to his s.136 detention, it does not appear that they offered any follow-up review or support to TJ.

54. TJ's mood was very up and down after this episode. Sometimes he was positive and did not drink for a couple of days, on which occasions he was able to talk you round to thinking that maybe he was OK. At other times he was drinking alcohol, not sleeping and staying up all night. We restricted his money so that he would not spend it on alcohol. I think it was around this time, in mid-August 2016 or so, that TJ said to us he wanted to kill himself.

55. Terry and I kept ringing support agencies to see if we could get help for TJ in this period. I cannot remember which support agencies exactly, but it was probably MIND or a similar mental health charity. Each time we were told that it had to be TJ who telephoned. I felt that he desperately needed help but that we were up against a brick wall. We felt increasingly helpless as we watched TJ spiral further before our eyes.

56. TJ had been offered a new job in London with a property management company. The job was supposed to start on Monday 22 August 2016, but TJ was due to appear in court the next day. He told Terry and me that he had sorted this out with his new employer and that he would not have to go into work that week.

57. TJ was due to appear at Highbury Magistrates' Court on Tuesday 23 August 2016 to answer his bail for breach of his restraining order. Terry and I gave him money to go to court, but he got drunk instead and failed to attend. He turned up at our daughter Charlotte's house at lunch time. I messaged TJ's Offender Manager, **[I/S]**, to let her know that TJ had not attended court and had used the money to go out drinking instead.

58. Terry and I went to collect TJ. We told him that he was killing us with his behaviour. Both of us were really upset. I think TJ was scared about what was going to happen if he went to court. We tried to take him to the local police station in Harwich, but it

was closed. Terry dropped him off in Clacton, and he stayed the night at his girlfriend [I/S] s house.

59. I understand that, as TJ had failed to attend court on 23 August 2016, a warrant was issued for his arrest on 24 August 2016.

25 August 2016

60. On the morning of 25 August 2016, Essex Police came to our house to look for TJ. Terry spoke with the officers and told them that TJ was not there as he was staying at his partner's. Terry said he would take TJ to a police station to hand himself in.

61. Later that afternoon, at around 5:00 pm, Terry rung the police to report that TJ had not turned up at his partner's address either. A transcript of this call was provided in the inquest process. Terry told the police he was worried about him, as he was suffering from depression and had threatened to kill himself the day before at the train station. Terry emphasised that TJ needed to be arrested and be taken to hospital. Terry also called TJ's probation officer, as TJ was due to attend a probation appointment that afternoon at 5:30pm. He advised TJ's probation officer that TJ had been drinking, and it was unlikely he would attend. We didn't know where he was during this time or what else we could do to find him.

62. Regarding TJ's second and final point of contact with mental health services later on 25 August 2016, [I/S], TJ's probation officer, was closely involved in the initial events leading to his admission to A&E. As I only attended later, whilst TJ was at the hospital, I have summarised below relevant elements of the witness evidence which she provided to the inquest. It is worth noting that TJ's probation officer had been TJ's probation officer for some time, and had observed first-hand his increasing alcohol use and deteriorating mental health throughout 2016.

63. In her inquest statement, TJ's probation officer states that, on the afternoon of 25 August 2016, despite the concerns raised by Terry, TJ did attend his probation appointment, arriving at 5.40pm. She recalled that, on arrival, TJ started crying and said he felt suicidal. He disclosed that he been sitting at the Train Station for several hours earlier that day, contemplating jumping in front of a train. He said he then left to make his way to their probation appointment however on the way stopped at a car park, where he disclosed that he stood [I/S] and thought about jumping off. When TJ's probation officer asked him what had triggered his suicidal thoughts, TJ referred

to missing his son and his criminal charges. He cited his son, parents and partner as protective factors preventing him from acting on these thoughts.

64. TJ's probation officer stated that this contact caused her concern over TJ's wellbeing. She therefore suggested to him that he should attend A&E, to which he agreed. Given her level of concern about him, she offered to attend hospital with TJ, which he also agreed to.

65. TJ's probation officer then discussed the situation with a colleague, [I/S], who suggested calling the Crisis Team first for advice. TJ's probation officer duly contacted NEPT's Access and Assessment Team, via the crisis line, at about 5:00pm, and explained her concerns over TJ's presentation. I understand that a summary of this call is included within the NEPT electronic case records, which includes the information passed over by TJ's probation officer about TJ's suicidal presentation at both the train station and carpark earlier that day.

66. The Crisis Team worker triaging the call also spoke with TJ on the phone directly, who confirmed the events earlier that day and was noted to appear "*full of guilt, remorse, depressed, anxious*". The corresponding clinical note of this call records that TJ appeared tearful and stated that he needed help, as he was "*concerned he may attempt suicide today*". The Crisis Team worker subsequently advised [I/S] TJ's probation officer to liaise with myself, and to bring TJ in to A&E that day to be assessed.

67. TJ's probation officer states that she and her colleague then drove TJ to Colchester General Hospital. In her statement provided for the inquest, she noted that on the way TJ said he had been drinking, though that both TJ's probation officer and her colleague had not realised this before given his presentation. She noted that TJ was not slurring, and she couldn't smell any alcohol on him.

68. TJ's probation officer recalls they arrived at the A&E department at Colchester General Hospital at approximately 6.15pm. TJ was then seen by an A&E Triage Nurse. The corresponding note of this triage, timed at 6:37pm within the Colchester University Trust hospital records, records:

"Accompanied by Probation Officer. He has been to the train station several times this week and sat there and thought about jumping. Then today he went to the top of a car park. He has had alcohol today, but is coherent and can tell his story. He says he feels sad, but doesn't know why."

69. The outcome of this initial triage was that TJ was referred for assessment by the Crisis Team. I understand that this is also known as the Access and Assessment Team, which has a psychiatry liaison service that sits within Colchester General Hospital, though was run at the time by NEPT.

70. After the initial triage, TJ rang Terry, and [TJ's probation officer] spoke to him after TJ passed the phone over. Terry explained he thought TJ should be kept in hospital, and that I would be coming to the hospital. I made my way over there straight away.

71. At around 8:00pm, TJ was seen by a Registered Mental Health Nurse, [I/S] who was part of NEPT's A&E Liaison Service. [TJ's probation officer] was present throughout this contact. She recalls that TJ was breathalysed by Nurse [I/S] in a communal area of the hospital, as there was no private room available. As TJ was over the limit, Nurse [I/S] advised that he could not be assessed at that point, however she proposed that TJ could stay overnight at hospital to be assessed the next morning when he was sober.

72. When I arrived, TJ and the others were still in the A&E reception area. I do not believe I was present when any offer of a bed was made, and do not recall being made aware by Nurse [I/S] that she had proposed this. Soon after I attended, I recall that someone, I think TJ, mentioned the outstanding arrest warrant. Nurse [I/S] then stated that she was unable to assess TJ and that he would need to hand himself into police custody. This is also the recollection of [TJ's probation officer], as detailed in her inquest witness statement. I was so confused and could not understand why the nurse could not treat TJ because of the warrant. TJ himself was silent during the discussion; Nurse [I/S] did not ask him anything.

73. I set out below what Nurse [I/S] recorded, at the time, about this contact in the corresponding clinical records:

"TJ attended A&E with his Probation Officer [PO]. He requested to see the A&E Liaison Nurse. Seen by [I/S], Liaison Mental Health Nurse. TJ admitted to drinking alcohol. Breathalysed at 20.10hrs and was over the limit at 80 (legal driving limit below 35). I advised TJ and [PO] that I could not undertake a Mental Health Assessment as TJ was not currently sober. I advised TJ that he might have to stay overnight in CDU and then be seen by the Alcohol Liaison Nurse and the Mental Health Team in the morning. [PO] advised that this would be good, as she feels TJP needs some help with his issues and that he has told her he is suicidal. TJP reported

he has been feeling suicidal, but is hopeful, if he gets the right help, things will get better. He wants to give up alcohol. His mother then arrived at A&E and attended our conversation. She stated that she felt it better if TJ, 'hands himself in to the Police.' I asked TJ's mother what she meant by this and PO *replied that there is a warrant out for TJ's arrest. I advised* PO *TJ and his mother that maybe TJ should attend the Police station, as there was a warrant out for his arrest and to be seen by their FME about his current issues. TJ stated that he would rather go to the Police station this evening and his mother agreed to take him there.*

Plan: To attend Police station and hand himself in as there is a warrant out for TJ's arrest. To be seen by the FME at the station."

74. Nurse **[I/S]** also provided written and oral evidence to the inquest. In her evidence, she confirmed she was aware of the events leading to TJ's presentation at A&E, including his suicidal ideation earlier that day, as well as the s.136 assessment on 9 August 2016. She stated that the initial plan was for TJ to say overnight in the Clinical Decisions Unit until he was sober and could be reviewed by the mental health team the following morning. Nurse [I/S] then stated that, on being made aware of the arrest warrant, she advised that TJ should hand himself in to police custody, where he could be seen by a Force Medical Examiner as this was the "*safest option*".

75. The are various aspects of Nurse **[I/S]** s account which differ significantly from my recollection of what happened, as well as that of TJ's probation officer as detailed in her evidence. I note that Nurse **[I/S]** claimed in her statement, and repeated in her oral evidence at the inquest, that I was "*cross*" with TJ on arrival and told him that he needed to go to the police station to be arrested. That is not my recollection at all. I was not cross with TJ: I was just really concerned and scared for his welfare. At no point did I instruct TJ that he needed to hand himself in nor, as Nurse **[I/S]** also claimed, did I agree with her view that TJ should be assessed in police custody rather than hospital. I specifically recall asking for TJ to be assessed, and being told by the nurse that she couldn't due to the outstanding warrant. TJ's probation officer also requested for TJ to stay in hospital to be assessed. Nurse [I/S] however was firm in her view that there was nothing she could do due to the outstanding arrest warrant.

76. I understand that Nurse [I/S] also stated in her evidence at the inquest that [I/S] TJ's probation officer has suggested there may be difficulties in TJ staying at hospital overnight because I worked there. I certainly did not raise any issues like this, nor do I recall this being said by TJ's probation officer If TJ's probation officer had said something like that, I would

have challenged it immediately as it made no sense: I worked in an entirely unrelated department. My sole concern – shared by TJ's probation officer - was making sure that TJ was kept in a place of safety to get the help he clearly needed.

77. I am also aware that Nurse [I/S] stated in her oral evidence at the inquest that she attempted to phone the police via the 101 number. I am positive that she did not do this while we were present.

78. When it was clear that Nurse [I/S] was not going to conduct a substantive assessment of TJ, we had no choice but to leave the hospital with TJ's probation officer. It was not a plan that either myself, TJ or TJ's probation officer positively agreed to. I understand that TJ's probation officer s evidence to the inquest was that I then telephoned the police, whilst we were outside the hospital, and they advised me to take TJ home. I think that I said to TJ's probation officer that the best thing to do would be to ring the police. I have tried very hard to remember if I called the police at this point. I was so distressed at the time, so I cannot positively recall making the call although I believe that I likely did. I reviewed my mobile phone records from the evening of 25 August 2016 and can see that I made four calls to the police 101 number between 18:03 and 20:49. Two of these calls were made at 20:49; the first lasted for 14 seconds and the second for 10 minutes and 51 seconds. I also understand that there are two short audio recordings of me ringing the police that evening and asking to be put through to Clacton police station.

79. I desperately wanted TJ to get help. Having been refused treatment at hospital, it makes sense to me that, as TJ's probation officer states I did, I would have telephoned the police and asked what to do next. I was so upset that TJ had not been assessed at the hospital. There was no way that I wanted him to just come home. I believe that I would have told the police that the nurse had refused to treat TJ. I would also have told them that she had said he should have a mental health review at the police station. I was so worried about TJ and the only way I would have taken him home that evening without trying to get him treatment is if the police had told me to do so.

80. On leaving the hospital, I also telephoned Terry to update him. I recall being so upset on the phone to him about the situation and that it seemed, yet again, that no one was going to help TJ. TJ's probation officer and TJ stood with me outside while I was on the phone.

81. After I got off the phone, TJ's probation officer left and I took TJ with me. He wanted to go to his girlfriend's house, but she was not in, so he came back and spent the night at our house. He seemed very lost at this time and subdued, we couldn't get much out of him.

82. Like 9 August 2016, TJ was once again discharged from hospital without any crisis plan or onwards referral. Both Terry and I felt at a loss about how to support TJ and keep him safe without any help from the mental health services.

83. It is necessary to add that, when I attended A&E on 25 August 2016, I was not told by anyone present and involved in TJ's review that he had active suicidal ideation, or that he had gone to different places (train station/car park) earlier that day with suicidal intent. Even though I was already very worried about TJ by then, that is vital information that should have been clearly communicated to me to ensure that I kept an extra close eye on TJ. They just let me walk off with TJ and put him in the car without any plan, advice, or proper handover.

84. Early the next morning, on 26 August 2016, TJ came with me as I drove to work. He said he was going to go to Colchester probation service and then hand himself in at the police station. He said he wanted to go to Colchester police station because it was bigger. Something seemed like it was not right with him on the drive, but I could not put my finger on it. He was nervous and kept jumping whenever I said anything. I dropped him off on [I/S] near where I work. [I/S] [I/S]

85. I was still worried about TJ when I got to work, so I rang TJ's probation officer to ask if TJ had arrived at the probation offices. I got through to her at about 12.30pm. She said that TJ had come in several times already and had said he was going to go to the police station. She said he also asked for money for a t-shirt. TJ's probation officer told me that she would call the custody suite to find out if TJ had in fact handed himself in. I understand that TJ's probation officer then called the police station, who confirmed that TJ had not handed himself in.

86. The next telephone call I received on 26 August 2016 was from the police informing me that TJ had died by jumping from [I/S] a car park [I/S]

87. I believe that TJ should have started getting treatment for his mental health problems, at the latest, after he was sectioned under s.136 MHA on 8 August 2016. He was actively suicidal at this point and already contemplating jumping before a train. A full

and robust mental health assessment would have identified his significant risk and helped prevent the further, rapid deterioration in his mental state that followed over the next few weeks. I was desperate to speak to one of the doctors or nurses who were assessing him at The Lakes so that I could explain that he would give them false reassurances that he was fine and downplay his symptoms. I am very upset that I was not given the chance to do so, nor was involved in the assessment. The doctors who assessed TJ did not even ring me back.

88. I am also very angry that TJ was not assessed and treated at A&E the night before he died. The clinicians involved knew that he was actively suicidal and had a known recent history of suicide attempts. TJ's probation officer had taken him there herself because she was so worried about him. He required urgent psychiatric intervention by this stage to keep him safe. Once again, however, he was discharged back into our care without any follow-up support or safety plan.

89. TJ had a heart of gold and never wanted to trouble anyone, but he was a serious danger to himself by August 2016. As I will set out in further detail below, I consider that the involvement of NEPT's mental health services on 9 and 25 August 2016 marked two critical missed opportunities to prevent the tragic death of our beloved son.

Admission

90. As explained above, TJ was never admitted as an inpatient. I believe that TJ should have been admitted, likely under the MHA 1983, to a mental health unit on either 8-9 August or 25 August 2016 to protect him. By then his risk of suicide was too high to be safely managed in the community, even by the crisis team. I believe that a proper mental health assessment on either of these occasions, which considered all the information available, including from us as TJ's family, would have led to admission.

Treatment

91. As set out above, there were a few brief periods when TJ was prescribed anti-depressants. As far as I am aware, he took the medication for a few months each time before stopping. I do not know why TJ made the decision to stop taking his medication on those occasions; maybe he began to feel a bit better. There is nothing in the GP records to indicate that TJ's compliance with his anti-depressant medication

was regularly monitored or followed up by his GP, nor that he was advised against stopping it.

92. I understand that the GP also provided TJ with some general information in relation to services to help with his alcohol issues, but I do not think that TJ ever engaged with any of these organisations. As I have summarised above, TJ was referred on several occasions to Rethink for his mental health issues but appears to have been discharged back to the GP each time without having been assessed. It appears that TJ was on the waiting list for talking therapies at the time of his death and was growing increasingly impatient with the delays in receiving this.

93. My understanding is that TJ never in fact received any counselling or therapeutic support. Sometimes he used to say he was getting help, but I don't think he was being truthful about this, as when we asked him more about it, he couldn't give any more information. TJ also appears to have been referred to the NEPT crisis team back in late 2012, however was discharged straight away from the service, without being assessed, on the basis that he was open to other services (Open Road and Rethink), despite the fact he was not receiving, and never received, any active support from these agencies.

94. I recognise that some steps were taken by the GP to signpost TJ to appropriate services and to prescribe medication. However, I have concerns about how TJ's mental health problems were identified and supported by the primary care services over the years, in particular the failures to regularly follow-up, make pro-active and repeated referrals to support services, and to involve us as his family. I think it is particularly telling that, despite TJ suffering from serious and long-standing mental health issues (including a history of overdoses), it was not until the month of his death, August 2016, that he first came into contact with Essex's mental health services.

95. When TJ did finally come into contact with NEPT's mental health services in August 2016, I do not believe that the decisions made concerning his care and treatment were in any way appropriate. This applies to both his s.136 assessment at The Lakes on 9 August 2016 and in A&E on 25 August 2016.

96. In respect of the s.136 assessment at The Lakes on 9 August 2016, no information was sought or taken from the family to assist the assessing team. We as a family had explained to the police, who we understood passed it on to the staff at Goodmayes Hospital, that TJ was very good at hiding how he was feeling. I also repeatedly sought

to explain this to the staff at The Lakes. TJ was very charming, confident, the life of the party and had the "*gift of the gab*" as they say. He was therefore very good at masking and hiding things. I had no doubt that TJ would play down his mental health issues in the assessment and focus mainly on his drinking, which he would say he would reduce. It was precisely for this reason that I requested that the consultant call me back before seeing TJ, which he never did.

97. If, during the assessment at The Lakes, anyone had spoken with me, I believe that the decision to discharge TJ would not have been taken. I honestly believe that TJ would, and should, have been admitted under section 2 of the MHA 1983 or at least as a voluntary patient. Absent my involvement, the clinical team wrongly assessed TJ's problems as solely alcohol related, relying on his account and assurances that he had no mental health issues. There does not appear to have been any attempt to investigate the triggers or history leading to his recent crisis which, if properly explored, should have identified TJ's significant mental health issues. A key route to this was by seeking information from TJ's family members who knew him the best and whom he identified, to the assessing team, as having a close relationship with. The failure to involve or communicate with the family is particularly upsetting given just how I close I was to the hospital (some 50 yards) and my repeated attempts to contact the ward.

98. I have similar serious concerns about the care TJ received from the A&E Psychiatric Liaison Team on 25 August 2016. TJ was in a state of active suicidal crisis. I believe that the Nurse should have, at the very least, insisted that TJ remain in hospital overnight in order to be assessed by the mental health team the following morning. In my view, however, it would have been best for TJ to have been transferred straight away to The Lakes for urgent assessment, after being seen by the Psychiatric Liaison Team. The A&E Clinical Decision Unit ('CDU'), where it was initially planned that TJ would be held overnight, is not an appropriate place for those in mental crisis, as the staff are not mental health professionals. Given TJ's suicidal state and known recent history, I believe he should have been transferred directly to The Lakes for urgent care and assessment from appropriately trained staff.

99. I cannot how understand how the existence of an arrest warrant was in any way a barrier to ensuring the clinical care and safety of a suicidal patient. I believe that, if TJ had been properly assessed at A&E, this would and should have led to his subsequent inpatient admission.

100. I was so shocked and confused by Nurse [I/S] s decision to discharge TJ back into our care. In her oral evidence at the inquest, she stated she felt "*confident*" TJ could keep himself safe on discharge as "*he had kept himself safe all day'.* I cannot understand how Nurse [I/S] could have come to this view, given she was aware that TJ had gone both to a train station and carpark that very same day with suicidal intent. TJ clearly needed to remain in hospital, under close clinical monitoring, until he was able to undergo a full mental health assessment for admission.

101. On both occasions that TJ was assessed by acute mental health services in August 2016, he was discharged without any onwards referrals or support plan in place. We were left to care for him, without any help, increasingly fearful about what might happen. In short, he and we were abandoned by the Essex metal health services.

Staff Arrangements, Training and Support

102. I did not get to see inside The Lakes in August 2016, as I was not invited to attend or feed into the assessment, so I did not see how the service was staffed or what it was like inside. However, as set out before, I have real concerns regarding the care the staff at The Harbour Suite provided, as, despite my numerous calls to the staff there requesting the consultant call me before TJ was assessed, I was never called back nor my views sought before the review took place. The importance of communication with, and involvement of, family members in mental health assessments within acute settings such as The Lakes should be a key part of staff training and policy.

103. I also have real concerns over staff training and conduct in respect of TJ's presentation at A&E on 25 August 2016. As I have explained above, I think that the decision to discharge TJ, without having been assessed and with no support plan in place, was entirely inappropriate. Mental health professionals working for an A&E Psychiatric Liaison Service like that should have clear training on how to assess patients who present with complicating factors, such as having substance misuse issues or being wanted by the police. It should be made clear that, in all these cases, providing a patient like TJ with the clinical care and treatment they require takes priority over everything else.

Individual Circumstances and Characteristics

104. TJ did drink heavily at times and took cocaine on occasions. As I have explained above, TJ's drinking worsened following the breakdown of his relationship and then

his sentencing in early 2016. When he attended A&E on 25 August 2016, TJ was breathalysed and he was over the limit. I feel however that the mental health professionals who saw TJ in August 2016 placed too much emphasis on his alcohol problems and failed to identify how these were related to, and likely caused by, his underlying mental health issues.

105. TJ was smart and he was charming. He was able to "hoodwink" people and convince them that he was OK by masking his true situation. I had tried repeatedly to warn the staff assessing TJ at The Lakes about this characteristic, so that they did not take him at face value. This appears however to be exactly what happened during the subsequent assessment on 9 August 2016, with the assessing team accepting TJ's false assurance that he had no mental health issues, and that his issues were *"entirely alcohol-related".*

106. I believe that TJ also had other issues that were undiagnosed, including bi-polar disorder, OCD and/or ADHD. His attention span was poor, and his moods would often go up and down. However, these issues were never to my knowledge investigated, by primary care or specialist services, which I think was part of the wider issue concerning the lack of communication with us regarding TJ's difficulties and issues.

107. At no point, during either of TJ's contacts with mental health services in August 2016, was I asked to provide any information in relation to TJ, including what I knew first-hand about his behaviours and risk factors. I believe that in order for a full assessment to have been carried out, the assessing staff could and should have spoken with me and/or other members of the family directly. If we had been spoken to, we would have given valuable information about TJ's recent deterioration and suicidal thinking. We also could have told them more about his mood changes, OCD tendencies and poor attention span.

108. If these issues had been investigated properly, I believe TJ would have received urgent mental health help in August 2016. This would have allowed him to receive a more accurate diagnosis and, in turn, appropriate treatment and better support in respect of his inter-related substance misuse issues. We as a family think more should have been done to investigate the connection between TJ's worsening mental health and substance misuse issues. However, TJ instead fell through the cracks.

109. I have been asked by the Inquiry about what involvement, if any, TJ had in any aspect of the decision to discharge him The Lakes on the day that he was assessed. I cannot

answer that question directly, because I was not involved in the assessment, despite my repeated requests to speak with the assessing team. However, from what TJ told me, and the evidence I received in the inquest, I understand that TJ explained to the clinical team that he did not have any mental health issues and just needed to get his drinking under control. As I have explained above, TJ was very skilled at minimising and distracting others from the reality of his mental health issues. He was as a result discharged back to the community, still in crisis, with no care or support plan whatsoever. No referral was made to the community mental health team, nor was a discharge summary sent back to his GP.

Engagement

110. I do not consider that TJ was sufficiently involved and informed of the decisions relating to his mental health care and treatment in August 2016. In respect of the assessment at The Lakes on 9 August 2016, I believe that the assessing team failed to sufficiently explore with TJ his relevant clinical background or the triggers for his recent crisis. Similarly, when TJ was seen by the A&E Liaison Nurse on 25 August 2016, she did not ask him any questions at all about suicidal presentation nor what support he would benefit from. TJ remained silent throughout the discussion.

111. On both occasions that TJ was seen by the mental health services in August 2016, the clinical teams failed to involve him in any discussion or planning about discharge arrangements. He was not provided with any crisis plan, nor it seems any information about support agencies or a crisis number to contact if he needed help in the community.

112. I can confirm that we as TJ's family were not involved in decisions relating to his care and treatment. In respect of both reviews in August 2016, no information was sought from us about TJ, his history, character or risk factors, nor were we invited or able to input into the clinical decisions made.

113. One of the R9 questions put to me by the Inquiry was whether we as TJ's loved ones were listened to. In order to be listened to, it requires a person to have a conversation with you. At no time did any of the mental health professionals involved try and speak to me about TJ to seek my views or gain further information about the events leading to his period of crisis. We felt entirely shut out from these important – and only – points of contact TJ had with the mental health services.

114. I can safely say that I was not listened to at all when I tried to raise my concerns about TJ to the staff at The Lakes on 9 August 2016. Despite my repeated calls to the unit, requesting that the assessing team contact me before reviewing TJ, no information was ever sought from or provided to me about the assessment. At the inquest, Dr [I/S], the psychiatrist that conducted the assessment, stated that she had not been told about my calls and that, if she had, she would have contacted me to obtain relevant information about TJ.

115. Even if I had not pro-actively asked to be involved in TJ's review at The Lakes, I believe my views should in any event have been sought. I am aware that the AMHP paperwork for this assessment contains specific sections for recording information about a patient's Nearest Relative and their involvement or views on the patient's care. Those sections were left entirely blank with respect to TJ's assessment on 9 August 2016, as the assessing team did not consider it necessary to consult with me or Terry, despite TJ reporting in the assessment having a close and supportive relationship with us.

116. I note that, in the account provided by AMHP [I/S] for NEPT's Serious Incident Investigation, she stated that she did not contact TJ's family on 9 August 2016 as she was not legally obliged to. In my view, that is not an adequate explanation. TJ had been brought into hospital under police powers of detention because he was such a high risk to himself. He was in a state of acute crisis. We, who knew TJ best and had been directly involved in the events leading to his assessment, should have been consulted. We could have provided key information about TJ's recent deterioration, which would have helped the assessing team better understand the full extent and severity of TJ's mental health issues.

117. My involvement was similarly not sought during TJ's review at A&E on 25 August 2016, even though I was physically present for some of it. At no point did Nurse [I/S] ask any questions of me about TJ's recent presentation or background, despite him having reported to her feeling actively suicidal. His probation officer and I both requested that TJ remain in hospital to be assessed, but it was clear that the nurse had already made up her mind that she would not assess him and was not listening to our concerns.

118. On both occasions in August 2016, we as a family were not provided with any information or any advice in relation to what to do to try to keep TJ safe on discharge. We were at a loss about how to protect him, without any crisis plan or support from

mental health services. I do not think I can be any clearer when I say that our concerns as a family over not being involved in TJ's mental health care in this period could not be any greater.

Concerns and complaints; the quality, timeliness, openness and adequacy of responses to concerns

119. I was not told or given any information about how to raise concerns or complaints over TJ's care during the two periods he was seen by mental health services in August 2016.

120. I raised concerns informally regarding TJ's safety when he was admitted to The Lakes on 8-9 August 2016, when I was constantly calling the ward to ask to speak to the doctor to explain my concerns about TJ's presentation. I remember the staff at the unit kept on saying they would pass the message on, and that TJ was alright, but they clearly did not. Nor did they ask anything about TJ's history despite the fact that he had been at a railway station threatening to kill himself the day before. I also tried to raise concerns about TJ being discharged on hospital on 25 August 2016 without being assessed. I believe on both occasions the mental health staff did not take my concerns seriously.

121. I did make any formal or informal complaints regarding TJ's care in this period.

After TJ's Death

122. I was informed of TJ's death by the police on 26 August 2016, who called me from an unknown number. I do not normally answer unknown number calls, but this time, I decided to answer.

123. Whilst the police handled this part well and were very kind, we feel as a family they handled the subsequent identification process very poorly. I remember we were taken to a small room the next morning, where the police officer made us answer all these questions, for at least an hour. We were made to physically stand there during this time, no chairs were provided, and were only told we had to answer all the questions for procedure. I do not remember exactly what questions were asked, and it was Terry who mostly spoke to the police officer. We thought we had to answer these questions as it was a police officer asking. However, looking back on it, we do not understand why we had to answer all those questions at that point, and it was badly

handled. This was a very difficult process and experience to go through, especially as we were then expected to go to identify TJ's body. I couldn't bear doing this, so my daughter [I/S] and her husband identified his body.

124. In terms of being told about other processes that would take place (for example internal investigations by the Trust or an inquest), I remember we were told that there might be an inquest, but weren't told what the process would be and how it would be handled. The police did explain they needed to investigate and confirm that TJ's death was a suicide, and that they needed to search TJ's bedroom as part of this.

125. In terms of support that was offered, I remember there was a chaplain person who offered bereavement services. She gave us some leaflets explaining what would happen next regarding registering or recording the death, as well as some leaflets on support services. However, we did not follow this information up, as we felt that it wouldn't be of use to us, though it may have been for others. I do not recall any support being offered by the Trust following TJ's death.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

126. Following TJ's death NEPT completed a serious incident investigation report ('SIIR') concerning their involvement in the events leading to TJ's death. The author of the report is [I/S], who was the Trust's Service Manager at the time. The report is dated November 2016. I believe we were provided with a copy of the report at some point around then.

127. I can confirm that we as a family were not involved at all in the investigation. I do not remember whether we were asked to be involved. I can imagine we would not have been in the right frame of mind to be involved even if we were asked. The report refers to staff interviews being taken from clinicians involved in TJ's contact. I can confirm that we were not provided with any of those interviews or any of the other source documents at the time (though I believe the medical records and some policy documents would have been later disclosed in the inquest).

128. Though the investigation claimed to be 'comprehensive' in nature, it was a very limited 12-page report. No real criticism of the care provided to TJ was made at all or any failures found. It was only through reading the report that I found out more information about what had happened during TJ's assessment at The Lakes on 9 August 2016 since, as above, I had not been involved in this process despite my

repeated requests. I was shocked to learn that the assessing team had decided that TJ did not at that time present with any mental health issues, and that his problems were solely alcohol related. As I had feared, the clinicians seemed to have just taken TJ's assurances that he was fine at face value, without investigating the triggers or causes for his recent deterioration and suicidal crisis the very day before. Despite this, the SIIR made no criticism of this assessment or the decision to discharge TJ without any support plan or referrals. Similarly, no criticism was made in respect of the A&E assessment on 25 August 2016, in particular of the nurse's decision to discharge TJ without assessing him solely on the basis that there was an outstanding arrest warrant.

129. The Trust's report seemed to just accept the accounts provided by the staff involved, without any attempt to explore or test this against the background information known about TJ's circumstances. Overall, it concluded that "*sound clinical decisions were made based on (TJ's) clinical risks at the time*". I cannot understand how **[I/S]** could have come to this view, in circumstances where TJ presented twice to the Trust's services, within a matter of weeks, in suicidal crisis, only to be discharged without any proper mental health assessment having taken place or any discharge plan or community support in place.

130. As far as I am concerned, the report is a cover up of errors. No 'Care and Service Delivery Problems' were identified by the Trust. In respect of the findings on 'Contributory Factors', the report does not contain any information in relation to the assessments, but refers only to TJ having "*poor impulse control whilst under the influence of alcohol*". In the 'Root Causes' section, the report concludes that "*alcohol use has contributed significantly to actions and decisions that (TJ) took which ultimately influenced his mood and decision-making*" in the period leading to his death. When I read that I could not believe that is what **[I/S]** chose to write. TJ was not even under the influence of alcohol at the time of his death. The attempt to attribute what happened to TJ's alcohol problems alone is deeply insulting and hurtful. It seems to us they are trying to lay the blame at TJ's feet, with no recognition of how seriously unwell he was, and how desperately he needed, and was actively seeking out, psychiatric support in this period.

131. As I said above, the report is not worth the paper it's written on. It is a whitewash.

Other Investigations or Legal Proceedings

132. I can confirm that there was an inquest into TJ's death and a subsequent Human Rights Act 1998 claim for damages against EPUT - Leigh Day represented me in both matters. In terms of other investigations, we were told by an inspector called DCI [I/S] that the police would investigate the matter given TJ's contact with the police in the period preceding his death. I was made aware during the inquest process that this investigation found that the police had acted appropriately in their attempts to locate TJ, after the warrant was issued for his arrest, on 25 August 2016. I do not remember being told about any other external investigations.

133. The final inquest was heard at Essex Coroner's Court before Senior Coroner Mrs Caroline Beasley-Murray, between 18-21 April 2017. It proceeded as an Article 2 ECHR inquest and took place in front of a jury. The jury returned a critical narrative conclusion which found that TJ's risk of suicide was not properly or adequately assessed and reviewed, and that adequate or appropriate precautions were not taken to manage his risk of suicide.

134. After the inquest, on 14 August 2017, the Coroner issued a Regulation 28 Report to prevent future deaths. The report was sent to Essex Police, Essex Partnership University NHS Foundation Trust ('EPUT', who I understand had by that point taken over the commissioning of the relevant services from NEPT) and Essex Community Rehabilitation Company (who were at the time responsible for the probation services). The report identified a number of concerns arising from TJ's contact with NEPT, including the need to involve family members in mental health assessments and the level of training/guidance for mental health clinicians in relation to assessing a person who was subject to an arrest warrant, with the evidence at inquest having indicated "*a lack of understanding as to the effect of a warrant upon the clinician's ability to assess and treat*". The report also raised concerns about the quality of record-keeping and call-handling at The Lakes, as well as the sufficiency of inter-agency information sharing and co-ordination between the mental health services, police, and probation services.

135. In terms of my experience of the inquest proceedings, I wish that there was more support and oversight in making sure the concerns identified within the inquest were followed up on and addressed. EPUT provided a response to the Coroner's Regulation 28 report, however I recall that this was very limited, only two pages, and offered only general assurances of change without any specific detail. For example,

EPUT claimed they had since introduced a 'new flow chart' and training for A&E mental health teams in respect of assessing patients who are subject to a warrant, but it did not explain what these new processes were or provide any supporting material. The response also claimed that the Trust had "*taken steps to reinforce to staff the importance of family involvement and ongoing communications*" without providing any specifics on what these new measures were.

136. After the inquest concluded, I wanted meetings and proof that policies and procedures had in fact changed. Despite my attempts to follow this up directly with EPUT, I was provided with very little information regarding how things had changed in practice. In the end I gave up trying to chase this up, as I felt I was getting nowhere with my enquiries.

137. I can confirm that the subsequent damages claim against EPUT case settled on 14 January 2022. The claim was brought under the Human Rights Act 1998, the Law Reform (Miscellaneous Provisions) Act 1934 and the Fatal Accidents Act 1979. The claim did not reach the stage of being issued. It settled following a Round Table Meeting with a payment of damages being made to us as a family. The payment and division of damages was subsequently approved at an Approval Hearing.

138. On 19 April 2019, we received an apology from the then EPUT Chief Executive, Sally Morris, apologising for the failure to undertake a mental health assessment and put a care plan in place when TJ attended A&E on 25 August 2016.

Expert Evidence

139. For the purposes of the civil litigation, my legal team obtained independent expert evidence in respect of the standard of care provided by NEPT at both assessments of TJ in August 2016. Expert opinions were obtained from both a consultant psychiatrist, **[I/S]** and a registered psychologist and psychiatric nurse, **[I/S]** although I understand from my solicitors that they were never provided to EPUT as the case settled before that became necessary.

140. I have been informed by my legal representatives that these reports, having been obtained in contemplation of civil litigation, are subject to legal professional privilege. I have however agreed to them being provided to this Inquiry as I believe they contain important critical findings on the care provided to TJ. Both experts have also been contacted in advance and have provided their permission for their reports to be

disclosed to this Inquiry. These reports are included within the list of documentation within my possession (see paragraph 152) in case they are considered of relevance to this Inquiry.

141. I would urge the Inquiry to consider these expert findings in full and with care. Both experts identified a series of shortcomings in the mental health care provided by NEPT, which stand in significant contrast to the limited, non-critical investigation report provided by the Trust. It is necessary to note that Professor [I/S] report focussed on the assessment on 25 August 2016 only, whereas [I/S] considered both assessments in August 2016, on account of their differing areas of expertise.

142. In respect of TJ's assessment at The Lakes, Dr [I/S] found that the s.136 assessment carried out by Dr [I/S] and the AMHP on 9 August 2016 was inadequate on several fronts. He found no evidence to indicate that the assessing team had sought to establish TJ's background history or triggers which had precipitated his recent crisis, instead focusing only on his alcohol problems. If TJ's circumstances had been properly investigated, Dr [I/S] considers this would have led to a "*more realistic evaluation of his suicide risk (as high)*" and an appreciation of the "*primacy of anxious and depressed mood that only latterly became complicated by alcohol misuse*". If a fuller, systematic evaluation had taken place at this point, Dr [I/S] considers that TJ would have likely, at the very least, been offered and accepted follow-up psychiatric care which could have reduced his risk to self. He considered these omissions amounted to a breach of duty (i.e. in negligence) and a "*missed opportunity*" to provide TJ with effective psychiatric intervention, which made a "*direct material contribution*" to his subsequent death.

143. Dr [I/S] was also critical of the failure to involve me in the assessment at The Lakes, recognising that I had collateral information which would have helped the clinicians form "*a better understanding of the hazards of taking (TJ's) apparently positive presentation at face value*". He was also critical of the failure by Goodmayes Hospital (run by NELFT) to conduct the s.136 assessment of TJ on 8 August 2016 on admission, instead of "*handing on*" TJ's case to NEPT as the s.136 unit at The Lakes on the apparent basis that this was closer to his home.

144. Both Dr [I/S] and Professor [I/S] concluded that the assessment on 25 August 2016 was inadequate and fell below the expected standard of care. Whilst both experts consider the initial view taken by the A&E Liaison Nurse to keep TJ in hospital overnight, in order for him to be assessed the following morning when sober, was

appropriate, they were highly critical of her subsequent decision to discharge TJ on the assumption that he would safely hand himself in to the police. Professor [I/S] considered this decision was "*wholly unreasonable",* explaining:

> *"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 as* [I/S] *who would have taken the decision to allow TJP to leave hospital."*

145. This view was shared by Dr [I/S]. He considered that Nurse [I/S] s unreasonable decision to discharge TJ demonstrated a "*rigid adherence to a legal protocol* [which] *was inappropriate, as it conflicted directly with her first clinical priority, namely to give adequate consideration to the full assessment of her patient".* Dr [I/S] identified the "*most egregious"* aspect of the discharge as the failure by Nurse [I/S] to implement the necessary care plan "*to provide a continuous level of care to an individual who was at a recognisably high risk of self-harm, instead returning his care to an effectively informal basis in the company of a relative".* Rather than discharging TJ to the care of his family, with no support, Dr [I/S] considered that, at the least, TJ should have been held in hospital until a clear line of communication had been established between the Liaison team and the police which, in itself, would have likely resulted in the police advising for him to stay in hospital for clinical assessment.

146. Both experts concluded that TJ should have been kept in the Clinical Decisions Unit at Colchester Hospital overnight, with a view to being assessed the following morning by a psychiatrist. Dr [I/S] found that, in such circumstances, the decision to discharge TJ from the care of the mental health services marked a significant breach of duty which directly contributed to TJ's death.

Your Views

145. I have been asked by the Inquiry to set out the issues that I am concerned about in relation to TJ's mental health treatment. I have already set out in considerable detail above the key concerns that myself and my family hold about the care TJ received from the Essex Trusts in August 2016. I will only therefore briefly summarise them here.

146. TJ himself didn't raise many concerns with us about his care, apart from complaining about delays to access talking therapies and issues with this GP over the years. However, as I have explained, he struggled to voice his struggles with us. It must also be remembered that TJ's first and only contact with the Essex mental health services was in August 2016, over a space of a matter of weeks, when he was already in a state of acute crisis. I do not think by then he was in a position to recognise or raise concerns about his care: he was so unwell, and everything escalated so quickly.

147. In terms of my views, I do not believe that what TJ received can be defined as mental health treatment. It was at best cursory and at worst he was simply brushed under the carpet. He never in fact received any treatment from NEPT as on both occasions in August 2016 he was summarily discharged, despite being in state of active crisis, without any provision for support or onwards referrals. I do not believe it can even be said that TJ ever received a formal mental health assessment from the Trust: the assessment at The Lakes was seriously flawed, for the reasons I have summarised above, and he was discharged from A&E on 25 August 2016 without any mental state assessment at all. In terms of any positive aspects of TJ's mental health treatment, I honestly cannot say that there were any.

148. I consider that one of the most serious failings in relation to TJ's care was the failure to engage with and involve his family. I have set this out in detail above; however, I am particularly troubled by the fact that no-one involved in assessing TJ at The Lakes sought to speak to me or Charlotte, his sister, despite both of us being involved in the events leading to his detention under s.136 of the MHA 1983. Both Charlotte and I had passed on messages (Charlotte via the police, and myself directly) to make sure that staff at Goodmayes and The Lakes were aware that TJ would try and *"pull the wool over their eyes"*. It is clear that this information was not passed on, or was not accounted for by the clinicians who assessed him. In addition, I am aware that staff did not contact the GP for any collateral information. If staff had spoken to any of us, we would have been able to communicate our serious concerns about TJ's declining mental health and his safety. I feel this was a crucial missing piece of the puzzle. I honestly believe that if staff had taken the time to communicate with the family that the outcome of the assessment at The Lakes would have been different, and that TJ would have been detained under section 2 for treatment and care. If this had happened, I do not believe TJ would have killed himself.

149. I also agree with the other concerns identified by Dr **[I/S]** in respect of the assessment at The Lakes. In particular, and linked to the failure to involve us as his

family, it seems that the assessing team failed to consider TJ's presentation in the context of his very recent suicidal episode. Too much weight was given to what TJ was reporting, and to his alcohol use, at the expense of investigating his underlying psychological problems.

150. I am also deeply concerned by how TJ was treated by the Trust's A&E Psychiatric Liaison Service on 25 August 2016. Having assessed that TJ was over the limit and could not be assessed, the Nurse's decision to discharge TJ back to our care, with no care plan or professional input, was entirely wrong. It should not have been on us, as his family, to protect TJ when he was in state of such obvious crisis. I was also not informed, by the clinical staff involved, of the full picture concerning TJ's risk at the time, which I consider was another serious failing. TJ should have remained in hospital and received a proper psychiatric assessment, as both of the experts in the civil claim concluded. I similarly believe that, if such an assessment had taken place, that TJ would likely have been admitted an inpatient under section. I do not believe that TJ would have gone on to kill himself if he had been given this protection.

151. TJ's death has affected our family more than I can ever describe. Terry and I have both been in a state of shock ever since. I still have the image of TJ on the roof of the car park stuck in my head. We never socialise anymore. Terry has real problems sleeping. We are both racked with guilt. I hope that this Inquiry can help finally bring us some closure and accountability for what happened to TJ.

List of Documents

152. Please see the below list of documents that I possess in relation to TJ's care under the Essex Trusts, in case any are considered of relevance to this Inquiry. These can be readily provided to the Inquiry, if and to the extent required:

List of Documentation in Karon Pimm's Possession		
Item	**Document Title**	**Date**
SECTION 1: INQUEST DOCUMENTS		
A. Coroner's Bundle: statements		
1.	Post mortem report	01.09.2016
2.	Toxicology report	23.09.2016
3.	Report by **Essex Police**	11.11.2016
4.	Statement of [I/S] & transcript of audio call of Terence Snr to police	25.08.2016

5.	Statement of [I/S] dated 27.03.2017 to produce call data	27.03.2017
6.	Statement of [I/S] dated 27.03.2017 to produce screen shots of front screen and intelligence report	27.03.2017
7.	Statement of [I/S] dated 27.03. 2017 exhibiting transcripts of audio call of Karon Pimm to police 25.08.2016	27.03.2017
8.	Supplementary report of [I/S] dated 31.03.2017	31.03.2017
9.	Essex Police Death or Serious Injury Report	
10.	Notes FAO DCI [I/S] from [I/S] dated 15.03. 2017 & 23.03.2017	15.03. 2017 & 23.03.2017
11.	Report by DSI [I/S] Essex Police regarding police contact with TJP 16.11.2016	16.11.2016
12.	Letter from Essex Police to Leigh Day dated 3.04.2017	3.04.2017
13.	Statement of Communications Officer [I/S] [I/S] dated 13.03.2017	13.03.2017
14.	Statement of Communications Officer [I/S] [I/S] dated 13.03.2017	13.03.2017
15.	Statement of Force Control Room Inspector [I/S] [I/S] dated 10.03.2017	10.03.2017
16.	Statement of Custody Inspector [I/S] dated 26.02.2017	26.02.2017
17.	IPCC letter to Essex Police 31.01.2017	31.01.2017
18.	Statement of PC [I/S] 25.01.2017	25.01.2017
19.	Statement of PC [I/S] 25.01.2017	25.01.2017
20.	Statement of PC [I/S] 25.01.2017	25.01.2017
21.	Statement of Police Officer [I/S] 8.08.2016	8.08.2016
22.	Statement of Mental Health Nurse [I/S] [I/S] 15.03.2017	15.03.2017
23.	Statement of [I/S] AMHP 09.01.2017	09.01.2017
24.	Essex Community Rehabilitation Company (Probation) Report by [I/S]	Undated
25.	Statement from [I/S] Offender Manager (Probation) 26.08.2016	26.08.2016
26.	Statement of [I/S] A&E Mental Health Liaison Nurse 04.01.2017	04.01.2017
27.	Statement of Police Constable [I/S] 17.11.2016	17.11.2016
28.	Statement of Police Inspector [I/S] 28.08.2016	28.08.2016
29.	Sudden and Unnatural Death Form	
30.	North Essex Partnership University NHS Foundation Trust Serious Incident Investigation Report	November 2016
31.	Report of Dr [I/S] GP 20.11.2016	GP 20.11.2016
32.	Report of Dr [I/S] GP 17.03.2017	17.03.2017
33.	Statement of Terence Pimm Snr to Police - identification of the Deceased and of items that were recovered close to where he died	15.9.2016

34.	Statement from Terence Pimm Snr	Undated
35.	Statement of Karon Pimm to Police 27.08.2016	27.08.2016
36.	Statement from Karon Pimm	Undated
37.	Statement of Charlotte Wood	Undated
B. Coroner's Bundle: Probation Logs		
1.	OASys Assessment (Redacted)	Multiple
2.	MOJ Contact Log (Redacted)	Multiple
C. Coroner's Bundle: Misc Documents		
1.	A&E Liaison Pilot Operational Policy	January 2014
2.	Essex Police Missing Persons Policy B1600	1 December 2015
3.	Essex Police Missing Persons Procedure B1601	1 July 2016
4.	Essex Police Incident 482 26.08.2016 (Redacted)	26.08.2016
5.	Essex Police Incident 190 25.08.2016 (Unredacted)	25.08.2016
6.	Assisting Investigation Officer **[I/S]** Rough Book Notes	Multiple
D. Coroner's bundle: submissions & inquest documents for family		
1.	Witness list running order	
2.	Agreed chronology	
3.	Submissions of family	12.12.2016
4.	Submissions of Essex Police 13.12.2016	13.12.2016
5.	**Submissions** of North Essex Partnership University NHS FT following PIR	**Undated**
6.	Note of Pre-Inquest Review 13.12.2016 (by Leigh Day)	13.12.2016
E. Other Inquest documents		
1.	Record of Inquest	
2.	Audio recording - call from Terence Snr to police	25.08.2016
3.	Audio recording - Karon Pimm - requesting to be put through to custody suite at Clacton	25.08.2017
4.	Audio recording - Karon Pimm to police - requesting to be put through to Clacton (2)	25.08.2017
5.	Essex Police Submissions pre PIR	13.12.2016
6.	Phone Records	25.08.2016
7.	Submissions on behalf of the Pimm family	12.12.2016
8.	Further submissions on behalf of the Pimm family	19.12.2016
9.	Transcripts of 2 x Karon Pimm calls to police on 25.08.2016	25.08.2016
10.	Updated witness list	4.4.2017
F. Prevention of Future Death Records		
1.	Coroner's Prevention of Future Deaths Report	14 August 2017
2.	Essex Police response to Coroner's Prevention of Future Deaths Report	8 November 2017
3.	EPUT response to Coroner's Prevention of Future Deaths Report	7 November 2017
SECTION 2: EXPERT EVIDENCE		

1.	Psychiatric Medical report – Dr [I/S]	December 2017 (updated 2018)
2.	Supplementary Psychiatric Report - Dr [I/S] [I/S]	July 2020
3.	Expert Report - Professor [I/S]	30 November 2019
SECTION 3: MEDICAL RECORDS		
1. GP records		
a.	Computerised print-out	
b.	Patient summaries	
c.	Admission and discharge summaries	
d.	Hospital Anxiety and Depression Scale (HADS) Reports	
e.	Sickness certificates and assessments	
f.	Grant of Bail	
g.	Correspondence from British Transport Police	
h.	Microbiology and X-ray records	
i.	Lloyd George Cards	
j.	Correspondence (general)	
k.	Patient registration documents	
l.	Miscellaneous documents	
2.	North Essex Partnership University NHS Foundation Trust Records	
3.	Colchester General Medical Records	
SECTION 4: MISC RECORDS		
1.	A&E Liaison Pilot Operational Policy	January 2014
2.	Apology Letter in from Essex Partnership University	18.4.2019
3.	Serious Incident Report - North Essex Partnership University NHS Foundation Trust	November 2016

153. Please see the below list of key documents, that I am not in possession of, which I would ask the Inquiry to consider obtaining and reviewing:

(i) Underlying SIIR source material, including staff interviews and contemporaneous accounts taken.

(ii) EPUT Regulation 28 supporting documentation, including revised policy/procedures for assessment of patients in A&E where there is an outstanding warrant.

(iii) Essex police policy material concerning inter-agency communication with A&E/mental health services and the management of individuals with mental health issues.

Recommendations for Change

154. In terms of recommendations for change, my first would be that there needs to be more involvement with family members regarding people's mental health history. TJ was excellent at masking his struggles and would often present as the life of the party. As mentioned already, professionals continually failed to involve or obtain information from us. If someone is having a mental health assessment, it should be standard practice to at least have a meeting with the family before they are discharged in order to ensure there is an appropriate plan in place and no risk-relevant information is missed. Mental Health Trusts should have a standard protocol in place for how and when to engage with family members, rather than just leaving it down to individual clinical judgment.

155. Also, as my counsel team said in our Opening Statement, people who are subject to criminal proceedings should have the same rights to psychiatric assessments and treatment as anyone else. TJ's case exemplifies the disconnect between the mental health and criminal justice services. His A&E assessment on 25 August 2016 was cut short due to the nurse's mistaken belief that she could not assess or admit TJ as he was subject to an arrest warrant. This betrays a fundamental misunderstanding as to the primacy of professional clinical duties, with TJ's 'wanted' status being prioritised over his mental health assessment needs. Police custody would not have been the 'safest' place for TJ, with access only to an FME.

156. I also wish for NHS Trusts to be held accountable through criminal proceedings when appropriate. If companies can be held liable for corporate manslaughter, so should public bodies and NHS Trusts.

157. I also have real concerns regarding staff training. As a nurse, I know that most training is now done online in front of a screen, consisting of just watching a video and doing a quiz at the end. These videos and quizzes get very repetitive, and there is a lack of accountability in ensuring staff are actually doing them themselves, rather than randomly clicking or getting other people's help. Training on key areas, such as risk management for instance, should be in person, as it was before, and involve a clear assurance process for checking that it is embedded in actual clinical practice.

158. Finally, there needs be substantial changes made in respect of the monitoring and implementation of Coroners' PFD reports. More support should be offered to families going through the inquest process to ensure that concerns identified in PFD reports are actively addressed. To go through all that time, resources and money during an

inquest, not to mention the additional trauma and distress it causes to bereaved families, only for there to be no means of ensuring that the necessary changes are made is a waste of a process, and means people continue to die.

159. In the PFD response provided from EPUT in TJ's inquest, the Trust stated: "*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".* This assurance was and remains empty: we know the same issues that affected TJ's care have recurred, time and time again, in respect of the deaths of others who were under the care of the Essex Trusts. The entire system needs to change. To ensure monitoring and oversight, the CQC or some other body needs to be informed of every single PFD report. I would welcome the suggestion of a new body to undertake this role as I understand has been long advocated for by INQUEST and other third sector organisations.

SIGNED: **[I/S]**

NAME: Karon Pimm

DATED: 4 June 2025