WITNESS STATEMENT OF ADAM ROWE PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **ADAM ROWE** (DOB: **[I/S]** of **[I/S]** am the son of the late Amanda Hitch (born on 20/10/1962 and died on 12/02/2022) **WILL SAY AS FOLLOWS**: -

2. I am making this statement based on my memory of events, from my understanding of my late mother's records / other disclosure and the evidence placed before the inquest (into my mother's death).

Diagnosis & Admissions

3. I did not become aware of my mother's mental illness until around the time of my parents' separation in 2011. I was 17/18 years old and remember that period of time vividly. It was around then that I became acutely aware of my mother's rapid mood swings. My mother usually a calm and pleasant person would suddenly become manic in her behaviour, very quick to anger and unpleasant.

4. I know that she had some sort of breakdown a couple of years before I was born. I learned this not only from my Uncle David but also vague references to it by my mother. My uncle would sometimes share his recollections from that period in an attempt to help us; me and my brother to understand her illness and give us some hope that she would get better. I also now know from her medical records that my mother actually had a history of long-standing chronic mental health problems for which she had been treated both as an inpatient and outpatient for many years.

5. My mother's initial diagnosis was bipolar affective disorder and resistant depressive disorder. A further diagnosis of enduring personality changes following mental illness was made later down the line.

6. My mother was admitted to the Linden Centre, Broomfield Hospital in Chelmsford in 2015. I recall that she was suffering with symptoms of psychosis. She told me that she was hearing voices in her head, and she thought buildings were moving and talking to her.

7. My mother had a habit of biting her nails when she was agitated. I remember seeing that she had bitten her nails right down to the nail bed so that they were bleeding. I can only imagine the severity of emotional distress that she must have been experiencing to inflict that level of physical pain on herself. Often when I visited her in hospital, she would seem really scared and say things like she thought someone was trying to kill her. Even when the conversation seemed to be more "normal" there always seemed to be an undertone of psychosis. For example, she would mention that the buildings were moving midway through a conversation.

8. I cannot express in words how distressing it was for my brother (Daniel) and I to see my mother in this state.

9. From this point on my mother was in and out of hospital. Mostly she would be very open about how she was feeling, her thoughts of self-harm and wanting to end her life, with both her family and the wide range of mental health professionals working with her. When feeling particularly distressed/ suicidal she would go to railway stations with thoughts of throwing herself under a train.

10. I recall during an admission in 2017 being told by the medical staff that the medication that she had been prescribed was not having the desired effect and that there was nothing more that could be done. My wife, who is a medical doctor, suggested that I raise the possibility of my mother having electro convulsive therapy (ECT) which I then did. The doctors treating my mother agreed to try this. Whilst I appreciated the fact that they were listening to me, I was very worried by the fact that I (supported by my wife – a medical doctor not a psychiatrist) were the ones driving my mother's treatment rather than the professionals looking after her.

11. I have set out below my best understanding of the most recent events leading up to and including my mother's death. Much of this information is gleaned from my late mother's medical records: -

12. On 9th July 2021 a meeting was convened between EPUT ([I/S] , Mandy's care coordinator), British Transport Police (PC [I/S] , the Network Rail Embedded Mental Health Nurse ([I/S]), my mother and her partner, [I/S] The reason for this meeting was that my mother's mental health was deteriorating and her trips to railway stations were becoming more frequent.

13. In relation to this meeting CCo noted: -

    a) *"We explained to her our roles and placed emphasis on our presence being to support and encourage her to choose safer methods of seeking help when in distress, as opposed to criminalising her."*

    And

    b) *"When asked why she attends the station she said something that resembled* ***"because I imagine myself on the tracks dead." (emphasis added)***

14. At the meeting a plan was discussed and agreed. The notes state: -

a) *"If Amanda presents again on the rail network and there are concerns about her welfare, contact her care team if in working hours 020 8272 4630.*

b) *If outside, the local crisis team can be located on 111 option 2. If she does not appear to be actively suicidal, partner* **[I/S]** *can be contacted and support her to return home he can be contacted on [mobile].*

c) *If she appears to be in a suicidal state/ in crisis please contact 111 option 2 and if risks have increased i.e. she accesses the train tracks and is not agreeing to go to A&E voluntarily detention is justified.*

d) *Plan:*

e) *Above information sent to care team*

f) *Any incident reports to please be sent to* **[I/S]** *@nhs.net to allow care team full understanding of the situation.*

g) *Will see if there is a role for HART."*

15. On 4 January 2022, my mother attended Rectory Lane for an appointment with **her CCo** and reported that she did not feel *"the support being provided by carers is at the hours requested"* in respect of domiciliary care **her CC** had assisted my mother in obtaining. **Her CCo** recorded that she will "*review with the care providers.*"

16. My mother also told **her CCo** that she had been going to the railway station when feeling suicidal again. **The CCo's** note states: -

a) *"Amanda said she has been attending the train station* **[I/S] and was concerned about being noticed by staff**

17. On the same day (4 January 2022), my mother also met with nurse **[I/S]** for her monthly depot injection of 200mg Zuclopenthixol Decanoate. **That nurse** recorded the following based on what my mother told her: -

a) "*said she feels low in mood all the time;"*

b) "*still feels depressed but denied any suicidal ideation or plans or intent to end her life;"*

18. My mother also expressed thoughts of "*hating her life;"* as said that she was spending most of her time in bed. She also reported that her friends had told me that

    a) "*her depot medication had not improved her mental state;"*

    It hadn't.

19. My mother's mood was rated at 5/10 and noted to be "*objectively flat and low in mood;"*

    a) Under the heading 'risk,' **the nurse** recorded "*suicidal ideation*" and "*overdose;"*

    b) The 'crisis plan' was for Mandy to *"call Rectory Lane duty worker 9am to 5pm.*

    c) *After 5pm NHS 111 option 2."*

20. Following this appointment, (also on 4 January 2022), **the nurse** sent an email to Dr **[I/S]** to ask if he could consider my mother's case prior to her planned appointment given my mother's reported side effects.

21. In the event, nothing was actioned, and my mother was not seen by Dr **[I/S]** until the scheduled appointment on 3 February 2022, a month later. The reported side effects and the concern that the depot medication had not improved her mental state was not considered before this time.

22. On 20 January 2022, my mother received a home visit from **the CCo**. At this appointment, the following comments were noted: -

    a) *"I went through Amanda's medication and it seems that she has not been taking her physical health medication;"*

b) *"I spoke to Amanda about the train station and she said she was going and sitting on the platform again;",*

c) And

d) *"Mandy advised that the carers are not providing the 12 hours support that I had requested. I advised her that I need to review this and look for alternative carers if needed".*

23. On 24 January 2022, I called **her CCo** as I was very very worried about my mother. I noted that in relation to this call, and based on what I told her **the CCo** has recorded: -

a) *"she has been sitting at train stations again,* **[I/S]** **and had concerns about being noticed** *She is now thinking that if she runs and jumps this will end her life. I reassured Adam and advised that I have a visit booked in with her and that I had seen her last week, and we did speak about the station, also advised of the appointment with Dr* **[I/S]** *"*

24. I recall that I was not at all reassured by this, I was extremely worried but did not know what else I could do to make the clinicians take on board how ill my mother was.

25. On 28 January 2022, my mother telephoned **her CCo** and it seems left a message. In the medical records, **her CCo** recorded: -

a) "*returned Amanda's call, she said she is struggling to sleep, this is not a normal presentation for Amanda as usually she sleeps too much due to her depression…* **her partner** *raised concerns that some staff that are attending Amanda's property are not encouraging her to take her medication when they visit. I advised I will raise this as this is why the care package was put in place……. Amanda said she was okay, but her presentation was that she is walking humped over and with her mouth open, she is telling she is okay and*

usually Amanda will say she is not okay. ***Amanda's presentation has deteriorated and I have advised*** her partner ***to call crisis over the weekend*** *if the sleep medication makes no difference and they can organise for her to have stronger sleep medication* ***or organise for home first to work with Amanda,*** *both Amanda and* her partner *agreed that no one wants Amanda to go in to hospital and that it would be best for her to be supported in the community."* ***(emphasis added)***

26. **The CCo** asked Dr [I/S] to prescribe medication. Promethazine was prescribed.

27. On 31 January 2022, my mother telephoned 111 and spoke to **[I/S]** of the EPUT 'W-Crisis 24' team. The following was recorded: -

    a) *"Amanda explained that she is feeling rubbish today, nothing more than usual has happened, but she feels she has nothing to live for, she spoke to her team about how she is feeling, they keep a check on her,* Her CCo *Social worker is who she spoke to today …* ***"She is having thoughts of going in front of a train,*** *she explained that the one person that stops her is* her partner *she is with him now. She does not self-harm ….*

    b) *"Amanda is not sleeping, and she is concerned about this, she states she get around 2/3 hours undisturbed sleep a night;"*

    c) *The plan was recorded as: "Referral to Sanctuary for a supportive call tonight. Handover to Rectory Lane in the morning. Utilise Crisis as and when needed."* ***(emphasis added)***

28. Later on, 31 January 2022, my mother received a call from **[I/S]** a Sanctuary Support worker. During this call, my mother disclosed suicidal intent with a current plan for <u>that evening.</u> In the notes, Ms **[I/S]** states: -

a) *"I contacted Amanda via a telephone call and introduced myself. Amanda stated that she felt 'rubbish' and had done so, for years. I asked Amanda; if she knew of any reason; why she felt particularly bad today.*

b) *Amanda stated; that there wasn't any particular reason for wanting to harm herself.*

c) *I asked Amanda; if she had anyone with her, for support. She stated 'yes,* **her partner**

d) ***I asked Amanda; if she had any intent, to harm herself tonight. Amanda stated**: 'yes'*

e) *I asked Amanda; to clarify what she had said.* ***Amanda stated; she had intent to 'kill herself tonight'."*** **(emphasis added)**

29. I understand that Ms **[I/S]** then passed the call to her manager Mr. **[I/S]**. In the notes, and in relation to Mr. **[I/S]**'s conversation with my mother, the following is recorded: -

a) *"He asked Amanda; if she had any intent to harm herself tonight. Amanda stated 'no'.*

b) *He asked Amanda if she had anyone with her for support. Amanda stated; 'yes'*

c) **He** *reminded Amanda that she has an appointment, with her care-coordinator tomorrow. (1st/2/22)*

d) *Amanda stated that she will be keeping the appointment."*

30. On 1 February 2022, my mother saw Nurse **[I/S]** for her monthly depot injection. During this appointment my mother reported specific suicidal intent and a specific plan to end her life by jumping in front of a train **[I/S]** **[I/S]** The notes record: -

a) "*Amanda appeared flat in her mental state and mentioned that she had contact NHS 111 crisis support last night …. "Amanda expressed her ongoing thoughts*

of wanting to end her life by jumping in front of the train [I/S] *Amanda said she cannot get over the breakup of her marriage and losing her home and job.* ***She stated that she feels suicidal and has plans to jump in front of the train****. Amanda told me that she had been staying with* her partner *over the weekend to prevent her from harming herself, but claims she does not know where she is going to stay tonight;"* ***(emphasis added) ……****"Amanda said she was visiting another service user* [I/S] *this afternoon but was not clear on her plans after leaving her friend ……****"Amanda said she has thought about jumping in front of the train today but wasn't sure of the speeds of the train*, [I/S] ***as to whether she would jump. She said she would wait to jump in front of a train*** [I/S] [I/S] ***" (emphasis added) ……*** *"Due to Amandas low mood and suicidal ideation, her care co* [I/S] *had requested for Amanda to be seen by the Duty worker after her depot was administered…. Amanda was seen by Duty Nurse* [I/S] *shortly after her depot."*

31. Specifically in relation to mood, **the nurse** recorded:

a) "*Mood. Subjectively feels depressed and suicidal, rates her mood as being 2/10. Reports to being lonely and that this is a trigger for her low mood. Objectively flat and low in mood but reactive on approach."*

32. On the same day (1 February 2022,) **her CCo** recorded:

a) *"Call to Amanda to let her know I was not in the office today due to isolating, no answer*

b) *Call to reception to let Amanda know and ask Duty to see her, admin advised that she was in the office and they will pass on message."*

33. In addition, I understand that my mother was also seen by a duty worker, Nurse [I/S] [I/S] on 1 February 2022 whilst attending her depot medication. (1 February 2022) **that nurse** notes-:

a) *"Community contact- Duty*

b) *Asked by* CCo *during morning mandatory meeting to follow up on Amanda as she was on the Crisis handover. Amanda was due to go to her depot this morning therefore was seen after.*

c) *Progress*

d) ***Amanda confirmed that she has thoughts to jump in front of a train**. We ran through her plans for today, she will catch a cab to her friends, go see* her partner *and then will go home. **I have asked where the plan to jump in front of train comes in, she stated "maybe when I go home".** She stated she has been having this thought for many years. She has not carried this out yet due to the timing of the trains and the speeds they are going. We have discussed what support she feels she needs and how best we can support her to prevent her from carrying out this act. She responded, "I don't know". She denied any illicit substance misuse nor any consumption of alcohol**. I have informed her that I will liaise with her cco and Home first**. I have discussed with* **her CCo** *including team leader* **[I/S]** *they have told me that this is an ongoing thought for Amanda, however* her CCo *has advised that I contact HFT to establish their views. I have spoken to* **[I/S]** *from HFT, she has confirmed that Amanda is well known. She stated that Amanda should be followed up by her cco tomorrow, and to be reviewed by her psychiatrist when she attends her medical review on the 3/2/22. Amanda has been informed of the plan, at this point* her partner *was present. Amanda told me she will be coming to Rectory lane with* her partner *on 3/2/22 for her medical review. She has been encouraged to continue to utilise the crisis line should she require support after hours.* ***(Emphasis added)***

e) *MSE*

f) *A&B: She appeared well kept. She maintained good eye contact, no evidence of her responding to external stimuli or aggressive behaviour noted.*

g) *Speech: Normal in all modalities*

h) *Mood: Subjectively she described his mood as "okay", objectively mood appeared quite flat with a lack of any sort of facial expressions however it appears this is considered normal for Amanda. When we finished the discussion, she was observed to smile when complimenting my hair.*

i) *Thought and perception: No evidence of thought disorder noted. Denied paranoia as well as visual and auditory hallucinations.*

j) *Insight: Present*

k) *Cognitive: Appeared intact Capacity: Appears to have capacity. Risks identified*

l) *Suicidal ideation:* ***She has thoughts to jump in front of train as she does not want to be here anymore. (Emphasis added)***

m) *Ideas of self- harm/injurious behaviour: She denied self- harming behaviours and thoughts to harm others.*

n) *Violence/aggression: No Neglect/vulnerability: No Safeguarding children & adults: No Physical health issues: Yes Hazards: No*

o) *Risk Management Plan*

p) ***-HFT have not accepted the request to make an referral based on Amanda's history.*** **CCo** *to follow up tomorrow, or via duty if* **CCo** *is not available.* ***(Emphasis added)***

q) *-Amanda to attend her medical review on the 3/2/22 with view of reviewing her mental state and establishing the need for any further interventions.*

r) *-See crisis plan. Crisis Plan*

s) *If in crisis, Amanda can make contact with services through the following numbers.*

t) *Monday – Friday 09:00-17:00 (excluding bank holidays) – 02082724630 Outside of these hours you can contact*

u) *NHS 111 option 2*

v) *Samaritans 116 123"*

34. On 2 February 2022, my mother was seen by [I/S] in the duty team. Mr. [I/S] recorded: -

a) *"Duty contact – call taken on behalf of duty worker. Amanda phoned to speak with someone from the team as she was feeling down;*

b) *I introduced myself, explaining that we have not spoken before and asked Amanda how I could help. Amanda was not initially forthcoming with why she had called or what was concerning her. She explained that she is feeling low and just wanted to speak with someone.*

c) *I asked what Amanda finds helpful about speaking to someone. She stated "comfort" and we explored what else she can find comforting or self-soothing. Amanda enjoys listening to Soul music and warm drinks. She explained that her friend* [I/S] *is a great help and she also keeps in contact with her two adult sons.* [I/S] *was in the background as we were talking.*

d) *I asked Amanda what has happened to day or changed of late for her to phone today. Amanda said nothing has changed and she has felt like this for 8 years. I checked PARIS records and noted she has a medical review tomorrow.*

e) *Amanda confirmed she will be attending with* her partner *at 11:30am. I encouraged Amanda to think about what she wants from the review. She said her medication isn't helping, so I suggested she mention this.*

f) *Mental state and Risk: Amanda reports feeling low today and says this has been the same for 8 years. She reports thoughts of ending her life. She denies any active plan or intent to harm herself and said that she does not want to*

harm herself. Amanda confirmed she will attend her review tomorrow; she has her partner *for support and we agreed a plan for this evening.*

g) *PLAN:*

h) *Amanda to engage in self-caring activities – listening to music, hot chocolate. Amanda has the contact details for NHS 111 and Samaritans. Attend review tomorrow."*

35. On 3 February 2022, my mother was seen for her planned medical review with her Consultant Psychiatrist Dr [I/S] Dr [I/S] recorded the following under the heading 'progress notes:'

a) "*I saw Amanda with her partner* [I/S] *for a medical review at Rectory Lane on 3rd February 2022. Specialty doctor Dr* [I/S] *was also in attendance. Although Amanda has moved to a supported living, she has been staying with her partner* [I/S] *for the last five days due to suicidal thoughts. In this respect, her presentation has remained more or less similar to previous presentations. She has continued to feel low in mood. She rates her mood as 0/10. She said she has been feeling like this for the last ten years and she has not noticed any significant changes in her mood/mental state. However, she enjoys going out with her friend and her presentation changes when she is with her son. She told me that she feels lonely and does not like to be on her own. She has a negative outlook about her life, and she feels like not wanting to be here. She frequently gets the urge to go to the train station. She said although she would like to act upon her thoughts of jumping in front of the train, she strongly denied any intention to do so. She cites her sons and partner as protective factors. She describes her sleep as fine and appetite as not good. She doesn't have any energy or motivation. Her concentration is not good. Her self-esteem and self-confidence are chronically low. She continues to feel guilty about leaving her family home many years ago. She continues to feel helpless and hopeless*

all the time. She strongly denies any thoughts of deliberate self-harm or harm to others. She feels paranoid when she goes out. She feels that people look at her. She denies any other anxiety or OCD symptoms. She denies misuse of alcohol or illicit drugs and sometimes she smokes. She has not reported any major side effects with current medication.

b) *With regards to her social circumstances. She has moved to a warden controlled flat (sheltered accommodation). She says she doesn't like her current accommodation. However, she is not sure what she would like to do with regards to her accommodation. She has a SDS care package, and the carers visit her regularly to motivate her in engaging with day-to-day activities. She says the carers do not spend a lot of time with her. I have discussed with social Worker* **CCo** *and she will look into this. Amanda speaks to her sons regularly. According to* her partner *previously said, she is a different person when she is with her sons. Her sons visit her as and when they can."*

36. Under Mental State Examination, Dr **[I/S]** recorded:

a) *"On mental state examination Amanda was casually and appropriately dressed for the weather. Good personal care was evident. She was calm and polite all throughout the assessment. She maintained eye contact but had a vacant look. I could establish viable rapport with her. She had slight psychomotor slowing down. She was quite brief in answering my questions. Her speech was monotonous. She described her mood as very low and objectively she sounded depressed. Her affect was restricted and she did not have any emotional expressions. However, she smiled while talking about her sons. She continues to have self-negativity and feelings of helplessness, hopelessness and guilt. She also feels worthless. She did not have any other thought disorder or psychotic symptoms. She has insight into her mental health difficulties. She was orientated to time, place and person."*

37. Under Care plan, Dr [I/S] recorded:

a) "*I have advised Amanda to continue with the same medication. I had a discussion with her Care Co-Ordinator, Social Worker,* **CCo** *She has agreed to explore change in the care agency in order to provide practical support to Amanda. I will review her again in four months. Care Plan Agreed: Yes. Care Plan Shared with Client/Carer: Yes.*

38. Under Risk Assessment, Dr [I/S] recorded:

a) *"Suicide ideation/intent: Amanda reports thoughts of not worth being alive. She also gets thoughts of going to the train station. Previously, she told me that when she sees a train passing by she feels calm. Although she has thoughts of jumping in front of the moving train, she denies any intentions at present. She cites her sons and partner as protective factors. However, there is a history of attempted suicide. In this respect risk is low at present but remains unpredictable.*

39. Dr [I/S] entry did **not** mention the period of crisis my mother had been experiencing just days prior in late January and early February which were clearly documented on PARIS. There is no reference at all by Dr [I/S] to my mother's contact with:

a) The contact with the Sanctuary workers on 31 January 2022 and the call in which my mother reported suicidal intent and plan to kill herself "*tonight*" to **the Sanctuary**.

b) The duty worker on 1 February 2022 who was asked to see my mother after she reported suicidal intent and plans to kill herself "*tonight*" by a specific means of jumping in front of a train;

c) The assessment by [I/S] on 1 February 2022 during which my mother reported specific suicidal intent and means;

d) The duty worker on 2 February 2022 when my mother called the team reporting low mood.

40. In his review on 3 February 2022, my mother reported her mood as 0/10, this was a deterioration of the previous 2/10 reported to **the nurse** on 1 February 2022, during which time my mother expressed suicidal intent with a plan.

41. It is clear to me that Dr **[I/S]** **failed** to consider the records added in the days prior to his consultation on 3 February 2022 which showed a sustained period crisis for my mother and repeated contact with services, and direct suicidal intent with a plan. Dr **[I/S]** failed to specifically consider whether my mother needed to be referred to the Home First team.

42. Dr **[I/S]** took no steps to consider whether he needed to notify British Transport Police about my mother's reported repeated attendances at train stations when in distress.

43. **This was the last contact that my mother had with an EPUT clinician before her death on 12 February 2022.**

44. EPUT employment specialist, **[I/S]** telephoned my mother on 4 February 2022 and again 10 February 2022. On both occasions, he went through to voicemail.

45. On 12 February 2022, my mother ended her life by jumping in front of a train. This was the specific method which she had told clinicians about during her contact with services on 31 January 2022 and 1 February 2022.

After mother's death

46. On 12 February at around 10pm, two British Transport Police Officers knocked at my flat. As soon as I saw them, I knew that my worst fear had been realised. They told me that my mother had died at [I/S] train station. I was devastated and went into shock… it was what I have feared the most but when it happened, I struggled to cope with the reality of it. My brother came to stay. We supported each other and tried to come to terms with what had happened and somehow get through those initial terrible few days,

Investigations

47. An inquest took place between 13-15 December 2023.

48. The Coroner recorded a narrative conclusion on how my mother came by her death which provides as follows:

    a) *"The deceased ("Mandy") died by suicide, but that is not the entire picture.*

    b) *While Mandy was someone who presented a consistent and enduring risk of suicide, such as to be chronic, my finding is that at the time that she died,* ***the level of risk that she presented was not sufficiently appreciated and not sufficiently addressed.***

    c) *Mandy had long- standing mental health problems, which in the months before she died were being treated by a community mental health team.* ***They were aware of the risk that she would kill herself by jumping in front of a train.*** *Plans were drawn up, including working with the British Transport Police, to address that risk. In November / December 2021 and J****anuary- February 2022, there was an increase in risky behaviours, but that did not lead to sufficient changes in the clinical response.*** *There was a suggestion that she be treated by the Home Treatment Team, but her case was not taken up. While the specific reasons for the Home Treatment Team not accepting her are not clear,* ***it seems she would have accepted that, had done so in the past,***

and her own team thought the Home Treatment Team to be appropriate. *There nevertheless was no formal referral, and in part, this appears to be because the view was taken that since the Home Treatment Team had not already accepted the request, the Community Team need not persist.* ***That was an insufficient response and*** *may be because the full picture was not appreciated- e.g. a contact with* ***services on 31st January in which Mandy had said that she had intended to kill herself that evening was not brought to the attention of any members of the community team****. So,* ***there was a change from Mandy merely talking about ending her life on the railway to saying that she would go to specific types of station and jump under train today. There is no sufficient explanation as to why a risk that seems so obviously very acute on 31st January and definitely (as the Community Team knew about this) on 1st February 2022, had subsided to something much less on 3rd February when Mandy was last seen by a clinician.*** *The Community Team had thought Home Treatment Team intervention to be appropriate, but her case was not even discussed or considered further. The position reached was not sufficiently informed or reasoned.* ***The situation was not helped by the fact that no formal risk assessment tools were used,*** *which (as the relevant policy says) can be used in combination with clinical judgment and inform it. The whole point of the Multi-Disciplinary Team is to share perspectives, and to arrive at a shared view. Despite the deceased's care co- Ordinator being sufficiently concerned about Mandy's case that she was phoning her colleagues about it when off ill, and the Home Treatment Team having been approached, the full picture was not available. Mandy's situation was never discussed in the Multi- Disciplinary Team at any point after these problems presented themselves in the time period mentioned above.*

d) ***There are plainly interventions that could have been taken and would have served to protect Mandy from the known risk, and not considering those contributed to her death.***

e) *Also relevant were problems in the British Transport Police protection plan. This may have created a false sense of security, in that the Care Co-Ordinator assumed she would be told of attendances at railway stations, but she was not. There may have been attendances at railway stations of which the clinical team were unaware, and there was a failure to pass on one such attendance on 21/11/21, though that was not of itself causative nor a contribution to Mandy's death."* ***(emphasis added)***

Legal Proceedings

49. My brother, Uncle and I are all very angry about the way in which my mother was treated and failed. We all believe that if she had been given the care and treatment she needed and deserved she would still be with us today.

50. We are now pursuing a Claim against the Essex Partnership NHS trust (EPUT) which is ongoing.

Recommendations for change

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

52. Create a better risk assessment tool. As the number of deaths being considered by the Inquiry makes it clear the risk assessments being used and relied on at the moment are woefully inadequate.

53. Appropriate (and by this, I mean having qualified staff on duty who can access a patient's medical history and make informed decisions about how best to manage crisis situations) services available out of hours – Mental health crises often occur during the evening or over the weekend. My experience was that it was virtually impossible to get any real or meaning full support if I tried to contact "emergency" contacts/ services out of hours.

54. There needs to be a change to the way patient records are kept as mentioned in the inquest. For example, the consultant could not immediately see reports, in a chronological order, made by NHS professionals outside of his team without actively searching in different areas for them. This means he did not see many of the highly concerning comments reported that could have influenced risk assessment.

55. I am unsure if any of my concerns raised via phone call or emails were acted upon or logged. There should be a more formal way of raising concerns about clinical decisions or lack of Health care professional action and logging such concerns from family to ensure that they are recorded and taken seriously.

List of Documents which I have:

Please see Appendix A

Statement of Truth

I believe the content of this statement to be true.

SIGNED [I/S]

MR ADAM ROWE

DATED 14/5/25

WITNESS STATEMENT OF ADAM ROWE PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

APPENDIX A – LIST OF DICUMENTS WHICH I HAVE

I. Inquest bundle

i. Record of Inquest:

1. Record of Inquest by Stephen Simblet, 15/12/23

ii. Statements

1. Adam Rowe (family), 16/10/23
2. [I/S] (carer), 18/10/23
3. [I/S] (care coordinator), 13/11/23
4. [I/S] (police sergeant), 21/02/22
5. Dr [I/S] (consultant psychiatrist), 06/12/23
6. Dr [I/S] (consultant psychiatrist), 10/11/23
7. [I/S] supported housing officer), undated
8. [I/S] (mental health practitioner), 10/11/23
9. [I/S] (police constable), 12/02/22
10. [I/S] (police constable), 12/02/22
11. [I/S] (police officer), 21/02/22
12. [I/S] (trainee fingerprint expert), 15/02/22
13. [I/S] (member of public), 14/02/22
14. [I/S] (police officer), 16/02/22
15. [I/S] (mental health nurse), 10/11/23
16. [I/S], 22/03/22
17. [I/S] (special constable), 12/02/22
18. [I/S] (police officer), 13/11/23
19. [I/S] (carer), 18/10/23
20. [I/S] (support worker), 27/11/23
21. [I/S] (police inspector), 12/02/22
22. [I/S] (taxi driver), 17/03/22

iii. Reports, Policy, Procedures, Training and Other Documents

1. British Transport Police Report by [I/S] undated
2. British Transport Police Report – Suicide/Mental Health Incident, 23/01/21
3. British Transport Police Report – Suicide/Mental Health Incident, 25/03/21
4. EPUT Adult Safeguarding Concern, 02/09/21
5. EPUT Care Programme Approach Policy, 01/07/17
6. EPUT Care Programme Approach Procedure, 01/07/17

7. EPUT Clinical Risk Assessment and Safety Management Procedure, 01/07/17
8. EPUT Patient Safety Incident Clinical Review by [I/S] 19/07/22
9. Exhibit PSS1 – Repeat and High Frequency Presenters Framework Overview, April 2020
10. Exhibit PS22
11. Exhibit PSS3 Harm Reduction Team 6-month overview, April-September 2021
12. Exhibit PSS4 Harm Reduction Team 17-month overview, April 21-August 22
13. Exhibits to the British Transport Police Investigation
14. Letter from EPUT Patient Safety Incident Management Team, 18/08/22
15. Patient Safety Incident Clinical Review, 19/07/22
16. Post-Mortem Report by Dr. [I/S] 15/02/22
17. Prevent Future Deaths report by Stephen Simblet, 19/12/23
18. Purchase order from Essex County Council to Redspot, 18/11/21
19. Toxicology report by Dr. [I/S], 16/05/22

iv. Medical Records

1. EPUT Medical Records
2. Ongar Health Centre (GP) Medical Summary
3. Redspot Care Communication Logs

v. Letters from Family and Friends

1. Adam Rowe in response to the 'Life Letter Questions', undated
2. Adam Rowe to Dr [I/S] 23/11/17
3. Adam Rowe to Dr [I/S], 09/04/18
4. Daniel Rowe to Dr [I/S] 09/04/18
5. Jackie Scurrell to Ms Hitch's doctor, 09/04/18
6. Tracey Dredge to 'whom it may concern', 10/04/18

vi. Submissions

1. British Transport Police submissions, 19/06/23
2. Family submissions, 14/06/23
3. Further family submissions, 29/09/23

II. Inquiry bundle:

vii. Statements

1. Adam Rowe Commemorative Statement, 20/09/2024