

THE LAMPARD INQUIRY

WITNESS STATEMENT OF BEN JACKSON

1. Preamble

- 1.1. I make this statement in response to a Rule 9 request received on 7 April 2025 in relation to my brother Edward (“Ed”) Jackson, who died when he was 18 years old on 31 December 2007 as an inpatient at the Maple Ward, Willow House, Severalls hospital, Colchester.
- 1.2. I am a scientist and reside near Edinburgh.
- 1.3. This statement is based on my knowledge and beliefs however I have considered documents, including documents that I previously had not seen, to provide as fulsome an account as practicable to assist the Inquiry. Where any information is not from my own knowledge or belief I make that clear below. I reserve the right to amend this statement when further documents become available.
- 1.4. I have sought Exhibits PS/001-011 regarding the HSE investigation into my brother’s death (along with others), including EPUT’s mitigation and response to the same as well as the inquest documents (being the ROI, PS-05b and additionally other inquest documents being the Prevention of Future Death report and transcript) from the Inquiry Legal Team. At the time of providing this statement they have not been disclosed to me.
- 1.5. I do not have any medical records or documents relating to Ed other than the documents I refer to here. I would prefer to have considered these documents before providing this statement and will file a supplementary statement should those documents be provided to me.

1.6. This statement is organised as follows:

a) Part 1: Facts

- Background
- Longview, Colchester admission (16 April 2006 – 9 June 2006)
- Community (June 2006 – October 2007)
- Southgate ward, Bury St Edmunds admission (October – December 2007)
- Maple ward, Colchester, admission (7 December 2007- 31 December 2007)

b) Part 2: Post death investigations and events

- Incident reports: 2007
- 7 day review: 2008
- SUI: 2008
- Inquest: 2011
- Edward House: 2013
- HSE prosecution: 2021

c) Part 3

- Diagnosis
- Admissions
- CAMHS
- SLA between Suffolk and NEPT
- Risk Management
- Safety
- Ward Environment
- Staffing

d) Part 4: Recommendations

Part 1: Facts

2. Background

- 2.1. Ed was born in 1989 in Ipswich, Suffolk. Ed was two years my junior. I provided details of our childhood in my commemorative account dated 29 October 2024 which I will not repeat in detail here. I miss my brother. I hope that the Inquiry makes practical changes to how mental health services operate and care for patients.
- 2.2. Our childhood together has had a positive impact on my life. We lived in quiet Suffolk villages and attended local schools together. We learned to fish together, would go cycling, and enjoyed spending time together at home. As a family we took holidays every summer usually this involved camping or staying somewhere in the UK. Ed loved the outdoors: cycling, fishing, exploring.
- 2.3. Ed was tall, handsome, good at school and had friends. Ed played in midfield for a local football team and was player of the season on at least one occasion.
- 2.4. Ed took his GCSE in May to June 2005. He gained ten A-C grades. My parents noticed that around this summer Ed sometimes would become quite angry and unreasonable. In their subsequent letter to the Coroner they explained that they believed in hindsight it was likely that Ed was in “turmoil” around this time. We had a family holiday that summer in Paris during which Ed was irritable and angry.
- 2.5. From my recollection Ed became increasingly unwell from around Autumn 2005. Ed transitioned to sixth form at a new school, but he left during the October half term. I do not recall why he dropped out of school, but my parents

reported that he was upset and could not be persuaded to go back. He started A-levels via a correspondence course.

- 2.6. I was living at home at the time but would leave for university thereafter, and in general, my parents protected me from a lot of the details of what was happening. Over time, Ed's behaviour changed, and he would become aggressive and threatening. His illness developed over several months, and fluctuated in severity. I certainly found it much more difficult to be around him after the age of around 16. I understand that my parents found it difficult to access help for Ed and I recall their frustration in knowing something was not right but being unable to get proper help for him.
- 2.7. I recall that after the onset of illness he developed the habit of becoming quite fixated on specific hobbies which he would pick up for a short period of time with an intense interest and then drop. For example he became very interested in foraging and gathering wild food. He learnt to ride a unicycle. He acquired and rode a petrol-powered scooter (a "go-ped"). My dad built him a halfpipe in our back garden to bmx on.
- 2.8. My mum contacted our GP but they were unable to see Ed unless Ed sought help.

3. Longview, St Aubyn, Colchester (16 April 2006 – 14 June 2006) – NEPT

- 3.1. In Easter 2006 Ed experienced what my parents described as a marked change in behaviour. He was unable to sleep for several nights; they stayed with him to help him sleep; he was pacing the house and would curl up in a foetal position. He would speak incoherently.
- 3.2. A specialist community Mental Health Nurse ([redacted]) from CAMHS West visited us and assessed Ed; he prescribed medication (Risperidone 1mg and Lormetazepam) but Ed refused to take it. The following night Ed was agitated and called the police reporting his delusional beliefs that my parents were trying to poison him. Ed ended up jumping from the first floor window

and running off to a friend's house before he was found by the police and taken to Stowmarket Police station under section 136 Mental Health Act 1983.

3.3. My parents were told that the police had tried to get Ed admitted to St. Clements Hospital in Ipswich but that he was not accepted there as he was 17 at the time. Ed was returned to Stowmarket Police Station where he spent the rest of the night. It seemed that Suffolk NHS did not have anywhere available for someone of Ed's age, but they contracted Essex NHS to provide a bed at Longview Adolescent Unit in Colchester.

3.4. On 16 April 2006 Ed was seen by [I/S] a mental health nurse, along with an approved social worker (ASW), [I/S] and it was arranged for him to be admitted to Longview.

3.5. I have now seen the admission information prepared by [I/S] and set this out this below [Letter CAMHS West to MDT at Longview dated 18 April 2006].

"There is a 1 - 2 week history of irritability, agitation and inability to settle. This has escalated to the point where he has not slept for the last 3 nights. He exhibits flight of ideas and some pressure of speech. His thoughts appear to be racing. He speaks of hearing voices although I think this is more likely an "internal debate" rather than true hallucinations. He is paranoid at times and becomes very angry toward his parents, storming into their bedroom in the early hours and ranting at them. He is preoccupied with physical symptoms and in particular, an operation (cosmetic) on his ears aged 6 years. At times he has been crawling around on the floor, at other times he has curled up foetus like. He denies using illicit drugs or alcohol. Previous to the 2 week history of increased activity and agitation, there is a six month history of increasing social isolation, dropping out of Sixth Form College in October and becoming gradually more withdrawn. He has low self esteem. He is not expressing grandiose ideas."

3.6. The diagnosis reported was *"Impression mixed affective disorder or manic episode, either discrete or possibly with the context of an emerging bi-polar disorder."*

3.7. Ed agreed to the admission, however, in what was subsequently accepted to be a significant error, he was detained under section 2 of the Mental Health Act 1983 between 16 April 2006 – 24 April 2006; thereafter he was an informal patient.

3.8. My parents made a complaint to Suffolk County Council about this who apologised and prepared a statement of facts (as it was not possible to delete the section from Ed's records [Complaint correspondence dated 25 April 2006; 15 June 2006; 29 August 2006; 14 September 2006,; 24 January 2007]). The complaint response [Letter from Suffolk County Council dated 29 August 2006] states that: *"the two doctors did complete medical recommendation for admission under Section 2 of the Act, as they were of the opinion that the statutory requirements for compulsory admission had been met in Edward's case. This meant that should Edward have changed his mind about accepting informal admission, the ASW would have been able to reassess and complete an application for compulsory admission without delay, and without the need for the two doctors to be called out again. Medical recommendations remain valid for 15 days and are destroyed, if not used during this period. Unfortunately [I/S] without thinking and without justification, also completed and signed the actual form to formally apply for Edward to be admitted to hospital under Section 2 of the Mental Health Act, and passed this over to the hospital together with the completed medical recommendations. Once the hospital found they had been given a duly completed application for admission under the Act, together with the two supporting medical recommendations, they had no choice but to regard Edward as a detained patient."* It was obviously a matter of serious concern to my parents that their son, who was a child at the time, had been sectioned inappropriately. I add that this was also a concern to Ed at the time. My parents reported that he had an innate sense of fairness and the fact that he was sectioned needlessly had a noticeable effect upon him. I understand that my parents pursued the complaint about sectioning after Ed asked them to do so as he felt it was unfair.

3.9. My parents visited Ed in Longview and we attended family therapy, although I had forgotten about this until I reviewed the documents. I do not know the details of his admission or what treatment he received; from documents it is reported that he attended individual therapy and education.

- 3.10. From a medical report for the CPA meeting dated 9 June 2006 his medication [CPA medical report dated 9.6.2006] was stopped on 18 April 2006. On a mental state examination on admission he reported his sleep was problematic and denied any abnormal thoughts. He believed his problems were due to “*sleep deprivation and poor parenting.*” It was stated on further examination that he had shown progress, was settled and there was no evidence of any mental health problems. This medical report concluded “*no mental health issues*” . This decision was subsequently criticised in the SUI and it was obviously very difficult for my parents as it meant that they were unable to get help with Ed when he deteriorated and became unwell again after discharge.
- 3.11. For the CPA meeting Ed also had a psychologist assessment which was later criticised in the SUI panel. In particular the psychologist (Dr [I/S]) concluded that Ed did not suffer any form of mental illness apparently on the basis of using Rorschach ink blot tests in addition to a test of his own devising which was “not psychometrically validated” [Dr [I/S] SUI interview].
- 3.12. These reports are different from the Education report for the CPA review [Education report dated 9 June 2006] which records: “*He was anxious, fearing failure and restless, needing to move around the room, but he was determined to keep trying. Edward said he would like to become more focused, more 'steady' and ready to learn. Gradually Edward's concentration improved so that he could complete work in short bursts. Now he is much more engaged and can work for almost a full session, although he sometimes shows some confusion.... Edward came to us in a highly agitated state. His condition has improved, he has engaged well in the classroom and he is now ready to plan his future educationally.*”
- 3.13. There is reference in the documents to Ed being kicked in the face by another patient. I do not recall this.

3.14. Ed was discharged from Longview on or around 14 June 2006. I am not aware of whether Ed saw CAMHS after discharge or the liaison that took place between Longview (NEPT) and Suffolk.

4. Community (June 2006 – October 2007)

4.1. My parents reported that after discharge, Ed never fully recovered or returned to his premorbid personality or level of functioning. He continued to exhibit concerning behaviour. He initially wanted to attend boarding school but pulled out of that. He started driving lessons but was reported to be reckless and threatened to crash the car to his instructor; my parents cancelled his lessons. My parents were very worried about him and the GP visited several times. My parents struggled to access appropriate support because his difficulties were labelled as "relationship problems." It was reported in the SUI panel report that the local CAMHS service in Suffolk only arranged one follow up appointment with Ed and then did not seek to pursue seeing him when he cancelled that appointment.

4.2. In spring 2007 Ed turned 18 years old.

4.3. During Easter 2007 Ed left home and drove on his motorcycle to our aunt and uncle's house in Yorkshire. What would normally have been a four or five hour journey by car took him 12 hours. My parents reported that he was in an agitated state and they were very worried about him. He lived with my aunt and uncle and exhibited aggressive, out-of-character behaviour. They managed, via a GP, to refer him to West Yorkshire Mental Health Services. He attended one appointment with a psychiatrist but then refused to attend again. I understand my parents went to West Yorkshire and met with the approved social worker who referred to a possibility of Ed suffering from schizophrenia. In June 2007 he returned to my parents' home.

4.4. I understand that after his return home my parents were able to get him referred to the Suffolk Early Intervention in Psychosis Team. A mental health nurse and social worker saw Ed at home on a number of occasions. It was

reported that he was difficult to engage with due to “*lack of recognition of any problems by Edward and he became very angry at times.*” [7 day report]. It is reported in the SUI panel report that he wanted to disengage. He was then referred to a consultant psychiatrist which he found upsetting. On 23 October 2007 Ed ran away from home again, leaving on his motorbike at 3.30am in an agitated state.

5. Southgate ward, Wedgwood House (October – December 2007) (Bury St Edmunds, West Suffolk)

- 5.1. On 23 October 2007 Ed was found by police near Grantham lighting a fire by the side of the road. He was taken to Grantham hospital for a check-up and from there he was transferred to a psychiatric unit near Grantham. From the records he was “*disturbed to the point where Intramuscular tranquillisation was administered.*” [SUI 7 day report dated 10 January 2008]. Suffolk Mental Health services sent Ed’s notes to Grantham and arranged for direct transfer to a bed at Wedgewood Unit, West Suffolk Hospital. By mistake Grantham sent Ed back to my parents in an ambulance.
- 5.2. Once he was back at home, the GP arrived at our house with an approved social worker and two police officers. The 7 day report refers to Ed making threatening remarks to my dad whilst holding a knife; I do not recall this but note that I would have been at university at the time, and that my parents protected me from a lot of concerning details.
- 5.3. On 25 October 2007, Ed was sectioned under section 2 of the Mental Health Act and he was taken in a police van to Wedgewood House, Bury St Edmunds.
- 5.4. I understand that Ed denied that he had psychotic symptoms. He was described as being “*very ambivalent*” about taking medication and a

consultant psychiatrist recorded that *“evidence of paranoid illness of which schizophrenia was a possibility.”* [SUI panel report, undated 2008]

- 5.5. My parents visited Ed regularly whilst he was at Wedgwood House. They reported that the environment was impressive. I’m not sure exactly what they meant but I think it is important to note the contrast between their impressions about Southgate ward, Wedgwood House and the Maple ward (see further below).
- 5.6. The 7 day report indicates that Ed was found to be psychotic, was guarded around any discussion about mental illness but was compliant with medication, Risperidone.
- 5.7. Ed tried to escape several times. I was aware at the time that there were concerns about him escaping. From my review of the documents the following events happened [SUI Panel report, undated 2008]:
- 5.8. On 3 November 2007, he was bought back by police after he stole a bicycle and attempted to steal a car.
- 5.9. On 6 November 2007, a Mental Health Review Tribunal panel maintained his detention. The 7 day report summarises as follows: *“Concern grew with his treating team of an emerging psychotic illness particularly due to what appeared to be negative symptoms of Schizophrenia and his guarded and suspicious nature. Note was made of him once having told his parents he “might as well not be living” (Report to Tribunal by Dr [I/S] 5th November 2007) as well as his parents having found knives hidden in his room along with a sharp item when clearing his room during the admission. Edward explained that he used these knives to self harm not to harm others which he disclosed at Tribunal”.*

- 5.10. On 9 November 2007 he absconded again and was found by police having stolen a taxi, handbag, and coat.
- 5.11. On 10 November 2007 [Bevan Brittan chronology prepared for Inquest, undated] Ed was placed on continuous nursing observations due to absconscions. According to documents from the inquest staff were concerned about threats Ed made about killing our parents and he was acting more bizarrely. It is reported that his administration of PRN antipsychotics and tranquilisers increased during this time.
- 5.12. On 12 November 2007, it is reported that he absconded again and was bought back by police. The 7 day report states he was placed on level 3 observations and after an hour he grabbed a fire extinguisher threw it through a window and jumped out after it, being bought back to the ward a short time after.
- 5.13. On 16 November 2007 plans were made to move him to a more secure unit. I understand from the records that at this time Ed was "*nursed in a low stimulant environment*". I'm not sure exactly what that looked like but it appears to be a deliberate approach to therapeutic milieu.
- 5.14. On 20 November 2007 Ed was detained under Section 3 of the Mental Health Act.
- 5.15. On 27 November 2007 Ed was found with a belt around his neck that had been secured to his bedroom door by a knot. He was reported to say that he experienced thoughts of suicide which became more intrusive when he was

feeling in a low mood. I was not aware of this event until I read the sentencing remarks in the HSE prosecution. My parents were not aware of it until they received the SUI panel report.

- 5.16. On 5 December 2007 Ed tried to escape by running through the courtyard and jumping over fence. It is recorded in the SUI report that he expressed thoughts of wanting to throw himself under train and that *“he requested that staff take his shoe laces as he did not trust himself”*. It is reported that the transfer to Maple Unit followed a review by his consultant Dr [I/S] [7 day report]. The SUI panel records the reasons for this as *“subsequently reported that prior to attempting to abscond he had experienced thoughts of wanting to go to the train station and throw himself in front of a train, and he was referred to Maple unit on 7th December 2007 due to the ongoing risks of absconding, self harm and fleeting suicide ideation.”*

6. Maple Ward, Willow House, Severalls Hospital, Colchester (7 December 2007-31 December 2007) (NEPT)

- 6.1. According to the documents [SUI panel report, undated 2008] Ed was referred to Maple Unit, Severalls Hospital in Colchester from Southgate Ward at 14.30, with copy of an initial care plan dated 20 November 2007; a risk screen document and assessment schedule dated 23 October 2007; plus medical notes. On 7 December 2007 he was transferred to the Maple Unit under the service level agreement (“SLA”) between Suffolk and NEPT. The SUI panel records that he was transferred due to *“due to ongoing risks of absconding, self harm and fleeting suicide ideation.”* He was under Enhanced CPA.
- 6.2. I am not aware of the transfer arrangements between Suffolk and NEPT but I would note that one of the key concerns for my family has been how and why Ed was transferred to the Maple Unit, which was a Victorian, prison-like, building and was self-evidently unsafe. If he had not been transferred to the Maple Unit it seems conceivable that Ed would not have died.

- 6.3. My parents first visited Ed on 8 December 2007, the day after his admission. They visited Ed as often as they could. However, they were told that they could not visit in the evenings, so they could only visit at weekend or days when they could both take time off work. It subsequently turned out that the information about evening visitations provided to them by ward staff was incorrect.
- 6.4. I set this out further below but their impression was that there was very little for Ed to occupy his time at Maple Unit and they had significant concerns about how the environment was not fit for purpose and that the staff were not fit for purpose. They report that, apart from watching television, there was absolutely nothing for patients to do within the unit and there was a complete lack of occupational therapy and psychology services.
- 6.5. I am not aware of whether Ed was given any information about his rights or how Maple Ward worked. I know as I will discuss later that his allocated Key Worker apparently worked nights so Ed did not get to see him.
- 6.6. When he was admitted on 7 December 2007 at 20.15 Ed was placed on level 2 observations. The SUI panel notedthat[:]: *"had been placed on Level 2 observations with four checks per hour to include active engagement for the purposes of assessment and high absconsion risk.. No definitive diagnosis .. Responding to internal stimuli and talking to himself..."*
- 6.7. On 9 December 2007, at the am/pm shift handover on the team decided to reduce observation levels from level two to level one as *"the picture was of settled behaviour."* [SUI 7 day report 10 January 2008]. This was reportedly when a NEPT risk assessment was completed by his key worker,

Staff Nurse [I/S] However, there is a factual uncertainty as to whether this was in fact completed (see below) on this day. The 7 day report noted that given the *“appearance of a pre incident risk management risk assessment after the incident”* a separate disciplinary investigation should be considered.

- 6.8. The SUI panel reports that it was recorded in the NEPT risk assessment which was produced after death (3 January 2008) [though dated 9 December 2007] that *“has not expressed suicidal ideas and no previous known attempts.”* Evidently it is a matter of grave concern to me and my family that this was entirely wrong, and may have been completed post death.
- 6.9. My parents record that on 9 December 2007 Ed’s belt and shoelaces were returned to him, despite my parents having been told the day before that they could not give him a portable music player to him as the earphone cables were a risk. If they had known about the previous ligature it seems likely that they would have queried this decision.
- 6.10. My parents recall that throughout his time on Maple Unit Ed lost weight. The transcript the ward manager for the SUI panel states that *“staff were concerned about his weight.”* He lost so much weight that his trousers were falling down. The evidence at the inquest was that Ed’s belt was returned to him as he had lost so much weight his trousers were falling down and other patients were teasing him. The SUI panel interview with the nurse, staff nurse [I/S] who stated *“one of those large journal clips, he had a journal clip there holding up his trousers, so I took that off him and I think it was at that point I gave him his belt”*
- 6.11. On 12 December 2007 ward review notes recorded that Ed expressed *“feel/s life is not worth living.”* The 7 day report states that Dr [I/S] (psychiatrist) decided to introduce an antidepressant to his treatment regime and noted that his mood was depressed.

- 6.12. On 18 December 2007 he was reported to be responding to internal stimuli.
- 6.13. On 19 December 2007 ward review notes recorded not responding to stimuli, no evidence of depression, speech more coherent, feels less depressed. He was granted a short period of ground leave.
- 6.14. On 21 December 2007 a decision was made not to grant him home leave for Christmas. I was not aware of this until I reviewed the documents. Whilst I am not a clinician, I find the decision to decline home leave to an 18 year old who was placed out of area and who was reportedly isolating heartbreaking and somewhat astonishing.
- 6.15. On 29 December 2007 my parents visited Ed for what would be the final time. They described him as agitated on this visit, similar to the way that he had been for the previous few months.
- 6.16. On 30 December 2007 they spoke to Ed and told him that they had bought him a Sony PlayStation and would bring it on their visit on 1 January 2008. This had arisen as they were concerned about the lack of activities on the ward. Their impression was that he seemed in good spirits on the call. This was the last time that my parents spoke to Ed.
- 6.17. On the same day it is reported that Ed was *“involved in an altercation with a fellow male patient who was intimidating him. It is highlighted in the notes the staff felt that this fellow male patient could be targeting Edward.”* [SUI 7 report dated 10 January 2008]. What appears to be bullying by another patient is of

concern to me, both in terms of behaviour, and, of course, of timing. I have further concerns stemming from Ed's young age on an adult ward.

6.18. From the records [7 day report dated 10 January 2008] on 31 December 2007 it is said that Ed appeared flat in mood and spending long periods of time by himself in his room. He requested to see the ward psychiatrist and had an "informal" conversation with Dr [I/S]

6.19. On 31 December 2007 a police officer attended our home in Suffolk and informed us of Ed's death. I was at home having returned from university for the Christmas holidays.

6.20. My knowledge of the circumstances of his death is from my recollection of the inquest hearing, the SUI investigation documents and inquest documents.

6.21. At 1735 on 31 December 2007 Ed was found hanging in his bedroom (bedroom 3, Maple Unit) from the curtain pelmet: [I/S]
[I/S]
[I/S] At the time he was reported to be on level 1 observations. It was reported that staff used ligature scissors and he fell to the floor banging his head. Resuscitation was attempted but was unsuccessful. Paramedics are reported to have arrived around 6pm. He was pronounced dead at 6.07 pm.

Part 2 Post death investigations and events

7. Incident reports

- 7.1. I have seen two incident reports dated 31 December 2007 completed by Charge Nurse [I/S] and support worker [I/S] which describe how Ed was found and the resuscitation attempts.
- 7.2. I have seen an NHS Incident Record (reference 073125) dated 1 January 2008 signed by the ward manager Staff Nurse [I/S] that includes the question *“Is the incident RIDDOR reportable? Reportable incidents must be telephoned immediately to the Health and Safety Advisor on 01206 228 654 and a copy of the incident form faxed...”* It is marked “Yes” that the event was reportable. It provides tick boxes for whether the event is clinical incident or other event.

8. 7 day investigation

- 8.1. The 7 day incident report was completed by [I/S] Clinical/Modern Matron and Operational Services Manager. He was called to give evidence at the Inquest. I understand that [I/S] went on to become the manager of Edward House, the new unit that was built in the Linden Centre and named after Ed (see further below).
- 8.2. The report notes that Ed was a patient of Suffolk MH Partnership Trust under a SLA by NEPT. In relation to admission the 7 day report states that *“All relevant procedures seem to have been carried out including a physical examination, re-reading of his rights and an initial care plan constructed.”* It is however noticeable that the SUI investigation found that CPA Care Plans dated 9, 18 and 21 December 2007 available within the case notes make no mention of low mood or suicidal intent history, and that no new care plan was developed following the ward review of 12 December 2007 during which Ed’s low mood was identified as requiring specific treatment.

NEPT Risk Assessment

- 8.3. The 7 day report refers to a handwritten risk assessment. The report explains that [I/S] (Operation Service Manager) upon reviewing the patient records found that there was no NEPT standard risk assessment, though there was a detailed risk history and assessment from Suffolk. Mr [I/S] asked Ed's key worker Staff Nurse [I/S] where the NEPT risk assessment was. He said that it had been done. The report says as follows:

"I asked him for the whereabouts of the risk assessment which he said he would provide for me as it had been done. This was not present on my visit to the unit the next morning and I requested C/N [I/S] pursue this for me as S/N [I/S] remained on night shifts. On the 2nd January I was provided with a photocopy of a handwritten risk assessment signed by [I/S] [I/S] and dated 9th December 2007. I further understand that S/N [I/S] subsequently approached [I/S] (PA to Dr [I/S]) asking her to file the original copy of this handwritten document within the patient record. This raises concerns around the presence of a risk assessment conducted by our nursing staff for this gentleman during his admission." Mr Carr recommended that this matter required further attention. It is a concern to me that the risk assessment was not completed promptly or may have been completed post death given the original was not on the file.

- 8.4. As referenced above one of my family's concerns at the inquest was that Ed's keyworker staff Nurse [I/S] worked night shifts and was therefore not able to fulfil his duties or be available to Ed. To the best of my recollection, our impression at the time was that he was working nights to build up his pension contributions. I note also that it was suggested by the ward manager of Maple Unit that there was a perception that some of the staff had "*retired on the job.*" [I/S] transcript SUI dated 30 April 2008].

- 8.5. I am not aware of whether there were any fact finding, management or disciplinary investigations into the completion of the NEPT risk assessment,

despite the 7 day report recommending consideration to a separate disciplinary investigation into this issue.

Return of Belt

- 8.6. The 7 day report found that there was no specific risk assessment in relation to Ed having his belt returned to him, nor information about who made that decision, nor when.
- 8.7. The report states that *“even though there had been no expressions of suicidal intent in the time on Maple Unit, it would be reasonable to expect a recorded rationale for the return of a potentially dangerous item.”* I note above that Ed was reported to have made statements that life was not worth living on the Maple Unit, had made a recent previous attempt on his life, and that it is objectively clear that a belt is a dangerous item.

Ligature points

- 8.8. The 7 day report makes comments in relation to fixed ligature points and that concerns about the curtains as a ligature point had been raised with the Risk Management department in October 2007. It is stated that a reassessment had taken place and it was *“agreed that current arrangements were satisfactory.”* No remedial work therefore had been carried out. The report states that: *“Information from Risk Management is that the last ligature risk assessment for Maple Unit had been conducted in October 2007 following C/N [I/S] call to Risk Management department. No action was noted as necessary at the time of this further assessment.”* This information was subsequently subject to scrutiny by the full SUI which made different findings.
- 8.9. The 7 day report made 4 recommendations as follows:
- a) *“A ligature review of Maple and Cedar units. It may be prudent to extend this review to other older style buildings where similar risks may be present.”*
 - b) *“For existing pelmets to be removed and curtains rails replaced with suitable alternatives”*

- c) *“A full SUI panel enquiry to be convened to look into the matter”*
- d) *“It may be deemed by the SUI Scrutiny Group that the issue re the appearance of a pre-incident risk assessment after the incident is dealt with as separate disciplinary investigation”*

8.10. It is obviously distressing to be made aware from the HSE prosecution sentencing in 2021 that prior to Ed’s death that there had been previous SUI reports raising environment risk assessments arising from two previous self-inflicted ligature deaths in 2004 in NEPT facilities as well repeat patient safety audits concerning ligature points. It is clear the Trust was well aware of the importance of checking for and removing ligature points on wards generally, and specifically on the Maple Unit.

9. **Serious Untoward Incident Investigation**

9.1. A Serious Untoward Incident panel was convened and was required to report by 2 April 2008. The panel members were [I/S] Associate Director of Nursing (Chair); Dr [I/S], Consultant Psychiatrist (Central) and [I/S] Team Manager Assertive Outreach Team (Witham). The Terms of Reference [Terms of Reference] included to consider the appropriateness of any care, treatment or supervision Ed received. My parents were interviewed by the SUI panel. The SUI panel made findings and recommendations in 9 areas: Longview, Referral Process, Risk Assessment, Documented Care, Staffing, Environmental Risk assessment, Supervision, Ward Culture and Staff Support.

Longview (NEPT)

9.2. The SUI panel found that at no point was there an indication that staff at Longview recognised that there was a significant period of build up to his acute presentation.

9.3. The SUI panel found that there did not seem to be any attempts by anyone to formulate a diagnostic explanation for the signs and symptoms observed in Ed which included *“long rambling account of presentation...thoughts are*

tangential...almost flight of ideas.. grandiose thoughts evident”, nor was any discharge summary prepared.

- 9.4. The panel were particularly critical of the psychologist’s assessment that Ed did not suffer from mental illness, which apparently relied in part on an unvalidated drawing game of the psychologist’s own devising, recording that: *“squiggling is a simple drawing game. The examiner scribbles a random line on a blank piece paper and the child turns it into something. One learns about the child’s main coping mechanisms. It is important to always hold in mind that this technique doesn’t give you the facts. It only helps you to think about the child, to try to understand the way the child responds to the outside world’. Despite these comments the conclusion drawn in the report dated 9th June 2006 was that Mr Jackson did not suffer from any form of mental illness. However the Panel noted that the report was ‘not yet conclusive as further testing was required to clarify his cognitive skills.”*

- 9.5. The panel recommended that the Trust review of the evidence base for the use of Rorschach ink blots and the squiggle test in any diagnosis of potentially psychotic symptomology; an audit should be undertaken of medical discharge summaries; any reports should be signed and dated; and that early onset psychotic illness in an adolescence can be very challenging such that any diagnostic decision be reviewed in light of ongoing problems.

Referral process: Transfer from Suffolk to NEPT – to Maple Unit

- 9.6. The panel found that the referral process to the Maple Unit appeared to be haphazard and informal, with no clear lines of clinical responsibility or decision making inherent within the process. The Panel were satisfied that relevant clinical information had been made available to the team at the Maple Unit at the time of Ed’s admission. However, the Panel were extremely concerned that:
- a) *There was no direct consultant-to-consultant discussion about the client either at the time of referral or at the nearest point possible thereafter.*

b) There was no indication that the Ward Manager had any involvement in the referral process.

c) There is no written formal referral procedure, leading to a lack of clear clinical responsibility and decision making on both an individual and team basis.

- 9.7. The panel recommended the Trust (MDT and Operational Service Manager) produce a comprehensive referral process and policy whether internally or under the SLA; the referral policy should clearly stipulate lines of clinical responsibility and decision making to involve the Consultant, Ward Manager and senior nursing staff; the referral policy should indicate the referral criteria and clinical information requirements including risk assessments, background information and current presentation.

Risk assessment

- 9.8. The panel made a number of findings concerning inadequate risk assessment and processes. It found that Ed was admitted with the Suffolk risk assessment which was “*comprehensive*” being 9 pages long and completed by Suffolk MHP Trust staff from Southgate ward. It recorded that Ed was a high risk of absconsion and that there was a risk of suicide. However, of the 9 NEPT staff at Maple Ward interviewed, only 2 staff said that they saw the risk assessment and 5 said they were not aware of any suicide risk. On admission there was no clear documented evidence that the risk of suicide specifically within the context of previous attempts has been acknowledged and subsequently discussed within the multidisciplinary team, so that the care plans fail to reflect that this is an identified need.
- 9.9. The panel found that NEPT staff had not discussed risk during handover or any point during admission.
- 9.10. The panel noted that the key worker Mr [I/S] stated that he did not see the Suffolk risk assessment until shown to him on 13 March 2008 and that his

own / the Trust's risk assessment dated 9 December 2007 stated "*has not expressed suicidal ideas. No previous known attempts.*"

9.11. The panel found that Ed's belt and shoelaces were returned to him on 9 December 2007 and that the decision to return the belt followed a discussion by nursing staff.

9.12. The panel made the following findings:

- a) *There was no reflection of suicide risk as identified within the Suffolk Risk Screen document within the Trust Risk assessment dated 9 December 2007*
- b) *There was no indication of suicide risk within the initial case note entry written by the admitting nurse*
- c) *There was a fundamental lack of knowledge of the previous suicide attempts highlighted by the Suffolk Risk Screen across the staff working in the Maple Unit, and even a lack of knowledge that the Suffolk Risk Screen document existed.*
- d) *There was no ongoing clinical risk assessment evident with the case notes*
- e) *There was no rationale within the notes for the return of the belt and laces*
- f) *There is no evidence that a risk assessment had been inputted onto Carebase*

9.13. The panel recommended that the Ward Manager and senior staff to ensure that an appropriate system of clinical risk assessment is implemented by the MDT as per the Trust's CPA policy; all staff to have mandatory CPA/Risk management training, noting that it was the responsibility of the ward manager; as well as specific recommendations on the risk assessment process being completed as appropriate but certainly on admission and shared with the MDT; risk assessments to be available on Carebase as well as in case notes and observations levels should be reviewed and agreed by the MDT team with decisions clearly documented as per the Trust's Observation policy.

Documented Care

9.14. The panel found that throughout his admission Ed's presentation was characterised by responding to internal stimuli, isolating and withdrawing from staff and fellow patients, and presenting occasionally as agitated. There was little monitoring of his depressive mood with nursing notes, the CPA plans dated 9 December, 18 December and 21 December made no mention of low mood or suicidal intent or history and that no new care plan was developed after his low mood on 12 December 2007 was identified as requiring specific treatment. The panel found that the key worker primarily working nights made the process of ongoing assessment, planning and evaluation difficult to carry out.

9.15. The panel made specific recommendations about care plans being reviewed to reflect changes in clinical presentation and need as well as clinical information being entered into case notes in a timely manner. On the role of the key worker it recommended the Ward Manager consider the need to ensure that staff undertaking night duty are not designated key workers or that there is a system to require continuity of care.

Staffing

9.16. The usual staffing levels was 4 staff in the day and 3 at night. On the day of the incident, 31 December 2007, the Maple Unit had three staff working on the afternoon shift, two staff nurses and a health care assistant, which increased in the late afternoon when another patient returned from leave. The panel investigated with staff from the Trust the operation of the bank system, Essex Mental Health Professional, finding that this had done little to alleviate staffing issues.

9.17. An urgent review of the *"issue of staffing"* on the Maple Unit was required. The Panel were concerned that *"the current staff are unable to provide the care required within a PICU environment, particularly in light of the repeated assertion that there is little for clients to engage in on the ward"*. There was an urgent need for the implementation of a programme of therapeutic activity

including urgent consideration of involvement of allied health professionals such as Occupational Therapy and Psychology. In addition it recommended a review of training, staffing levels and procedures for absences.

- 9.18. It is shocking to me that there was a clear finding that staff were unable to provide care to patients. I am not aware of what steps NEPT took in relation to this but it worries me that years later the same concerns seem to be present.

Environmental Risk assessment

- 9.19. The SUI panel interviewed staff members who said that there were concerns about pelmets for “quite a long time”, that this was raised to the Risk Assessment Department and that they had been assessed previously with no remedial action identified. However, the SUI panel recorded contradictory information from the Associate Director who said a ligature audit found the pelmets were too high, the Operations Services Manager who said he had no specific memory of pelmets being an identified risk and the Ward Manager who stated that no concerns about ligature points on the unit had been raised. I understand that the Operational Services Manager was Mr [I/S], who did the 7 day review and the Ward Manager was Mr [I/S]. I do not know who the Associate Director was at that time.

- 9.20. The panel stated: *“The Panel was concerned with the degree of inconsistency in the reporting of and dealing with issues of environmental risk. It became apparent that there are no written records, either on the ward or within the Risk Management Department, of specific areas of concern being reported other than the audit reports, last completed prior to this incident in 2006. the panel has not been able to establish the facts around this issue of the utmost concern.”*

- 9.21. It was a significant concern to my family that the SUI panel was not able to get to the bottom of concerns being raised by staff about curtain pelmets and the Trust’s approach to environmental risk assessments. I have asked for the

HSE investigation documents from ILT and it would be of assistance to consider these before I provide any final comments.

- 9.22. The panel recommended that the Trust give urgent consideration to the re-provision of the Maple Unit. I believe this recommendation led to the development of Edward House (see below) which opened in 2013. I am not aware of what happened to patients and whether they continued to be sent to Maple Unit despite this finding in the intervening years.
- 9.23. It recommended that there should be an urgent review of staffing levels within the Risk Management Department to enable the development of effective systems and processes; it recommended written records be kept and that outside specialist training should be provided to staff undertaking environmental risk assessments.

Supervision

- 9.24. From interviews with staff the SUI panel found that although a supervision structure was in place it had not been implemented in an appropriate and effective manner.
- 9.25. It recommended that a system offering appropriate and effective supervision was put in place for clinical staff; that it be a robust system and that the Operational Service Manager have oversight in order to implement an action plan.

Ward Culture

- 9.26. The panel made the following findings about the ward culture. It said that it had been described as *"Institutionalised' and of 'haughty superiority' with no therapeutic activity available"*. Additionally, the Panel were concerned that the staff viewed the ward as *"chaotic"* with *"high activity"* and a *"lot going on"*.

9.27. The panel was concerned about the isolated nature of the unit and recommended management consider strategies which would lead to a greater rotation of staff and that the Ward Manager take a more active role.

Staff support

9.28. The SUI panel considered staff support after Ed's death. It recorded that the debriefing session was not found to be beneficial to staff; it found that staff reported being angry and disillusioned.

10. Inquest

10.1. The inquest into Ed's death took place from 27 September 2011 to 4 October 2011 some 3.5 years after he died. I am not aware of the reason for the delay.

10.2. My parents protected me from a lot of the goings on so I do not have full information but I did attend most of the inquest. From my memory the atmosphere was fairly cordial with the NEPT staff initially but then it changed over the course of the inquest as more information emerged. There was evidence that there were severe failings at the Maple unit.

10.3. The inquest was held at Essex Coroner's Court before HM Coroner Mrs C Beasley Murray sitting with a jury. I have asked the Inquiry to provide me with a copy of my brother's Record of Inquest which I understand is an exhibit to Paul Scott, EPUT's CEO statement (PS/05) but this has not been provided to me. I have also asked for a copy of the Prevention of Future Death report and any transcript or legal submissions that may be available from HM Coroner or EPUT. At the time of preparing this statement none of these documents have been provided to me.

10.4. From my recollection the jury reached a narrative verdict which stated words to the effect that Ed took his own life, whilst the balance of his mind was disturbed and went on to list multiple factors which more than minimally

contributed to his death, which I no longer recall perfectly, but which I believe included words to the effect of “a lack of therapeutic activities”.

- 10.5. My family were unrepresented at the inquest so I prepared the submissions on the verdict on our behalf. I feel strongly that families should have equality of arms in inquests and that it was unfair that my family did not have legal representation. I had never been in a court room before. It was an incredibly difficult experience hearing a lot of new distressing evidence whilst coping with grief and doing our best to hold NEPT to account.
- 10.6. The Trust were represented by Bevan Brittan LLP. I remember my mum’s anger that the state was paying for the Trust to be represented but not us. At the time this was complicated by the fact that the inquest was held more than three and a half years after Ed’s death, and that in the meantime, the Trust had proposed building a brand new facility named after Ed with the promise that all it would right all the wrongs that had been allowed to occur in Ed’s specific case.
- 10.7. I recall that at one stage the Trust’s solicitor or barrister intervened when the key worker Mr [I/S] was giving evidence by saying that he did not have to incriminate himself, or words to that effect. Our experience of the process was that it was to some extent adversarial. For example, we made submissions that a neglect verdict could be left, which the Trust’s legal representative argued against. As far as I can recall it was not.
- 10.8. I believe a Prevention of Future Death report was issued by HM Coroner.
- 10.9. I have not been provided with information about any action NEPT took in relation to the investigations, inquest or Prevention of Future Death report.

10.10. My family did not bring civil proceedings in relation to Ed's death. I am not fully aware of the reason for this nor am I aware of whether NEPT made any admissions in regard to Ed's care. I do recollect a sense of my parents not being motivated to place monetary value on their son's life. Having now been represented in the Inquiry I understand that the failings were indicative of a strong claim against NEPT.

10.11. I exhibit the following documents from the inquest [Witness List; Issues explored at inquest document; Submissions from family dated 4 October 2011; Letter to [I/S] dated 7 November 2011; SLA with Suffolk dated 29 September 2011; Statement of [I/S] 15 September 2011, Letter from Mr and Mrs Jackson dated 13 September 2011; Dr Millard psychiatric report dated 26 August 2011; Letter to Coroner from Suffolk MHT dated 25 July 2011; Submissions from the Trust dated 15 July 2011; Letter from Mr and Mrs Jackson dated 14 July 2011; Letter to Coroner from Suffolk MHT dated 12 July 2011]

11. Edward House, Linden Centre Chelmsford

11.1. In August 2013 Edward House was opened. This was a new 20 bed low secure unit named after my brother. From my recollection there were discussions about it opening from around the inquest. I have photographs of my parents and I ceremonially revealing the plaque on the day of its opening [Photographs]. We understood that the Unit would be everything that Maple ward was not, that it would be bright, modern with therapeutic activity.

11.2. The Annual report from 2013/14 describes it as "*a new purpose built facility in Chelmsford for treating people with complex mental illness, requiring conditions of stability, safety and security.... Edward House is named after Edward Jackson, a young man who sadly took his own life in 2007 whilst in care.*"

11.3. From the Exhibits that have currently been disclosed to me as a core participant in this Inquiry I am not aware of any deaths having taken place at Edward House (see AS02-01) however as you can envisage this matter causes me worry.

11.4. I have been informed by my lawyers that there is reference to what are described as “near misses” on Edward House (in 2015, 2019, 2020 (‘harm short of death’), three in 2022 and two in 2023). There is no further information about these events and I invite the Inquiry to provide me with further details about them.

11.5. I am aware from publicly available information that a nurse faced fitness to practice proceedings after he left a razor where patients could access it in 2023. The Essex Live report dated 27 January 2023 states that he was given a conditions of practice order for 18 months with a review after a panel found the charge proved on the balance of probabilities and amounted to serious misconduct. I would ask that the Inquiry investigates this further.

11.6. I have complicated feelings about Edward House. At the time of its opening it felt like a genuinely positive outcome from otherwise tragic circumstances. It may be that this has been, overall, the case. But the circumstances of this Inquiry have raised in my mind the possibilities that its implicit promise has been broken and/or was not genuine in the first place. These possibilities have compounded the sense of injustice I feel regarding Ed’s death. My view is that if an inpatient unit was to be named after my brother then it should be an exemplary unit where patients are safe and receive the highest standard of care. Anything less compounds the injury caused to my family.

12. **HSE Prosecution**

12.1. On 20th November 2020, at Chelmsford Magistrates Court Essex Partnership University NHS Foundation Trust pleaded guilty to a charge that, during the period from 1 October 2004 to 31 March 2015, it had failed, so far as was

reasonably practicable, to manage the environmental risks from fixed ligature points within its inpatient mental health wards thereby exposing vulnerable patients in its care to the risk of harm by ligature. The judge said the following about Ed, who was known as EJ in the judgment:

“EJ died on 31 December 2007 from a ligature suspended from a curtain pelmet on Maple Ward, Willow House. The SUI noted that the patient had made previous attempts with a ligature tied to bedroom door and raised concerns about the confusing and contradictory evidence they received about risks and audits and a lack of records regarding concerns which were raised other than the audits, despite various members of staff giving evidence that they had raised concerns about the pelmets presenting a risk. The SUI recommended that the Trust should address the issue of outside specialist training for those employees undertaking the task of environmental risk assessment to enhance knowledge and skills in this area. The SUI recommended that the ward environment should be assessed for risk on a regular basis specifically for ligatures, including actions to ensure robust reporting and the keeping of written records.”

- 12.2. I was only very vaguely aware of the HSE prosecution at the time it was taking place and did not participate in it. I was not asked to provide any information for the prosecution.
- 12.3. As I set out in my commemorative account the judge’s words stayed with me. Mr Justice Cavanagh said: *“... each of the [...] people to whom I will refer in greater detail in a moment died by their own hand by hanging in one of the Trust’s mental health wards, but it does not follow that they really intended to commit suicide. It is often the case that such attempts are made as a cry for help without the desire actually to die.”* This still resonates with me when I think about Ed and how desperately and lonely he must have felt on the evening of his death.

12.4. I would like to know the actual facts of the patient safety audits that EPUT/NEPT undertook in relation to ligature points and specifically curtains and pelmets.

12.5. I add for completeness that I was not involved in the non-statutory inquiry.

Part 3 Rule 9 Questions responses

13. I will now address the specific questions asked by the Inquiry in the Rule 9 response dated 8 April 2025 where not otherwise addressed above.

14. Diagnosis

14.1. I have set out above how Ed's mental illness developed and the circumstances as known to me. I would only add that at the time he had multiple diagnoses over the period of his illness which varied from 'being a bit odd', or words to that effect, to 'schizophrenia'. In hindsight there seems to have been a lack of diagnostic certainty. My understanding is that he had a psychotic mental illness with no definitive diagnosis at the time of his death but was likely in the prodromal phase of schizophrenia.

14.2. As I have stated a major concern for my family was that Ed was left without adequate support when he was deemed to have no mental health issues during his inpatient admission at Longview, and the considerable barriers this created to my parents and him being able to access appropriate community mental health treatment and care for him. My parents were told that with schizophrenia (if indeed that was what Ed suffered from), early treatment is beneficial, but, in practice, it was 18 months between Ed's admission to Longview and his subsequent admission during which time he had had only fleeting contacts with West Yorkshire Mental Health Services, Suffolk NHS and Lincolnshire NHS. This was in my view a missed opportunity to provide him with early intervention and care for his mental illness.

- 14.3. I retain of sense of pain and frustration experienced by my parents in the face of multiple changing diagnoses combined with a situation when Ed was not getting better.
- 14.4. Dr Millard, Consultant Child and Adolescent Psychiatrist was commissioned by HM Coroner to provide an expert opinion, as was another expert, Dr Royston. I have seen Dr Millard's report dated 26 August 2011 but not Dr Royston's. This states "*Diagnosis of schizophrenia.... I note Dr Royston's clear account of the diagnosis of schizophrenia. I would add that in adolescence the diagnosis is often less clear, particularly early in the course of illness and that it is often easier in hindsight to make a diagnosis than it is at the time of first presentation. Early identification of psychosis is usually based on recognising psychotic symptoms in the first instance, with treatment and monitoring over time before reaching a definitive diagnosis of schizophrenia.*"
- 14.5. I agree with the SUI panel recommendation that diagnoses should be reviewed in light of on-going problems. This seems important for children, given my experiences with Ed.
- 14.6. Dr Millard concluded that "*Even given the difficulties of diagnosis of early psychosis, I think there was sufficient information for this possibility to be included as part of a differential diagnosis which may have led to an agreement with EJ and his parents of why it was necessary to monitor his mental health. This monitoring could have been by local community child and adolescent mental health service or by the early intervention in psychosis service depending on their local agreements. The focus of the engagement could have been through family work to improve relationships between EJ and his parents and to assist EJ with employment planning and educational. This monitoring could then have led to more rapid treatment if they detected deterioration in his mental health... The lack of follow-up is concerning. The*

one offer of appointment and follow-up letter may be appropriate for a very low risk referral. However, I would have expected more effort to be made to keep in contact with a young person who had been so disturbed in his behaviour that he required admission under the mental health act. Even if he did not have a psychotic illness, there must be a risk that on discharge, the same home situation would lead to a relapse of the challenging and risky behaviour”

15. Admissions - NEPT

15.1. As set out above Ed was an inpatient in NEPT hospitals commissioned by Suffolk Mental Health Trust under the SLA between Suffolk and NEPT. He was an inpatient in Longview (April – June 2006) and Maple Unit (December 2007).

15.2. In relation to Longview, as set out above the main concerns we had as a family was that Ed did not receive a diagnosis, appropriate care planning or support from CAMHS when he was discharged.

15.3. Dr Millard reported as follows: *“EJ’s mental state on the ward was initially disturbed but by the end of six weeks the medication assessment was that he did not have any ‘mental health problems.’ There does not appear to have been any integration of the information about his previous mental state and acute presentation with the potential impact on early psychosis of a period of antipsychotic treatment and the potentially stabilising effect of admission. It is unclear at what point the opinion on the unit switched from treatment of an acute hypomanic episode to managing a family relationship difficulty. It is not clear from the notes what Dr [I/S] (consultant psychiatrist) “initial thoughts” about diagnosis were nor how the parents had responded. The after care seems to be have been planned on the basis of his apparently settled mental state at the time of discharge rather than looking at the entirety of his illness.”*

15.4. My parents had concerns about the Maple Unit including that it was a very depressing environment, and they raised concerns about the commissioning process by Suffolk.

16. CAMHS

16.1. I have concerns that the CAMHS in Suffolk was not adequate and did not properly provide ongoing support for Ed after his discharge from Longview.

17. SLA between Suffolk and NEPT

17.1. It was a matter of concern to my parents that Suffolk Mental Health Trust had failed in its due diligence by referring patients to the Maple ward which was known to be unfit for purpose. They raised concerns with HM Coroner stating that:

Our concern relates specifically to whether NHS Suffolk exercised due diligence prior to entering into the contract with North Essex Mental Health Trust:

- a) Was Maple Unit properly assessed prior to the commissioning?*
- b) If so, were ongoing assessments made in order to ensure continued suitability?*
- c) What were the "clear understandable measures of performance" used?*
- d) What are the "required standards" alluded to on the web page?*
- e) Clearly when you read the SUI panel report, these standards cannot possibly have been met, which leads us to ask:*
- f) Who agreed this piece of commissioning – at what level within Suffolk PCT?*
- g) What experience in Mental Health did these people/this person have?*
- h) What experience and knowledge in psychiatric intensive care did they have?*
- i) Did they have a mental health qualification?*
- j) When did anyone from NHS Suffolk visit the unit to make sure it was fit for purpose?*

17.2. Upon receiving the SUI panel report they queried

- a) What internal investigation (if any) did NHS Suffolk instigate?*
- b) What was the outcome of this investigation?*
- c) Why were we not involved in this investigation?*

17.3. I agree with all of these issues raised by my parents. I invite the Inquiry to investigate these questions bearing upon NEPT. In a statement to the Inquest, [I/S] Suffolk Primary Care Trust stated that there was "no

specific record” of being notified of any failing in the quality of service provision before Ed’s death or admissions. It was stated that *“Unless serious concern associated with the Maples had been identified, Suffolk PCT would have been unlikely to undertake quality or safety assurance visits where these matters have been delegated.”* To my mind this raises questions about what NEPT told Suffolk commissioners about the environmental risk assessments, previous serious incident reports or any other concerns arising.

17.4. I understand that the Suffolk Commissioner sought *“expedited action based on the recommendations in the 7 day report and they further made it clear that Suffolk would not be placing patients in the Maple Unit until the substantive SUI report had been received and actioned.”* In the statement to HM Coroner there is an extracted email from February 2007 in which Suffolk raised concerns *“why was a belt reissued when suicidal ideas had been recorded and lack of risk assessment.”*

17.5. The statement does not address when placements started again but presumably there was some information that the SUI recommendations had been complied with. I have not seen this.

18. Risk Management

18.1. There were categorical failures to provide safe care for Ed. It worries me that there were missed opportunities before his death to safeguard the unit and address ligature points. Further, there were failings in his clinical care and management, such that for example his care plans did not refer to the risk of suicide and suicidal ideation. My recollection of CTI’s opening statement on 4 April 2025 when introducing Dr Davidson and Ms Nelligan was that they had provided evidence to the Inquiry to the effect that *“there can be no such thing as a ‘risk-free’ environment”*. I find this proposition troubling to the extent that it has the potential to distract from, or excuse the non-addressing of, situations which fall far short of any reasonable standard of care.

- 18.2. I am concerned that my brother displayed a number of behaviours that would seem to me to warrant concern and clinical review including increased observations. For example I know that EPUT states that a number of factors would lead to a patient being on a higher level of observations such as personal safety, self-neglect, absconding, physical illness, change in behaviour. At the inquest we were told that Ed was given his belt back by a member of staff prior to his death. The evidence was that Ed isolated himself on the Maple Unit. He lost a lot of weight. He was mocked for his trousers falling down by other patients. Losing weight would appear to be a sign of self-neglect, as would his isolation from others. We were also told that Ed was able to lock himself in his room prior to his death. I understood from the evidence at the inquest that Ed was teased by other patients and he was actually hit by another patient the day before he died.
- 18.3. The care planning was criticised in the SUI investigation and agree with those findings and recommendations.
- 18.4. I understand that the role of the key worker has been described by EPUT in evidence to this inquiry and is to co-ordinate care on the unit, ensure that the patient has a basic understanding of what will happen in the facility, their responsibilities and orientation in the ward environment. From our experience there was no co-ordination of Ed's care on Maple ward. He was left largely on his own without adequate co-ordination of his care or risk management.
- 18.5. It is a concern to me that it remains unclear whether Mr [I/S] did in fact complete a risk assessment on 9 December 2007 as he said he did and whether there was any disciplinary investigation into this. The risk assessment that was produced for the 7 day panel was in any event inadequate and factually wrong.

19. Safety

19.1. I am concerned to read about Ed being bullied by other patients and being punched by another patient. As set out above these would appear to be obvious safeguarding issues that should have triggered a review of his care and specific support, particularly bearing in mind Ed was only just 18 years old and was allocated to an adult ward.

20. Ward Environment

20.1. My position is that if Ed had not been transferred to Maple ward he would not have died.

20.2. The Maple ward was a Victorian prison-like environment. It was a house that formed part of a Victorian asylum complex. It has been described in the documents as a “problem unit.” The SUI panel that visited the site described it as “*appalling*” and the bedrooms were like “*cells*.” [I/S] transcript dated 30 April 2008]

20.3. The SUI panel interviewed staff members. I refer to below the interview of Ward Manager [I/S] as he made a number of comments about the ward environment. He stated as follows: “*It’s a very isolated unit... An attitude of haughty superiority, where certain people were attempting to improve practice and change processes were told that they were ‘neurotic bitches and to leave things alone’. If signs were put on the wall they were immediately ripped down and shredded and that’s what I found. Hence the number of disciplinary cases that are going on and have gone on. I have never known so many staff be disciplined in one unit in such a short period of time*” I find this extremely worrying and it echoes the concerns my family had and heard at the inquest that there was a poor staff culture on the ward.

20.4. I have not received any further information about disciplinary cases arising prior to Ed’s death, nor any disciplinary cases arising from the circumstances

of Ed's death (including the investigation recommended by the 7 day panel into Mr [I/S]).

Staffing

20.5. It was a significant concern to my parents that the staffing levels on the Maple Unit were inadequate and incompetent. I note that the SUI panel heard evidence that staff nurses did not know how to complete a care plan and risk assessment.

Part 4

21. Recommendations for change

21.1. At this early stage of the Inquiry I am not in a position to propose final recommendations that I would invite the Chair to make, not least as I do not have all the documents relevant to Ed's specific case, let alone across the Inquiry. I have set out above the key areas of concern I have.

21.2. I would like to provide some preliminary thoughts to assist the Chair at this stage but will revise these going forward. I welcome the Chair's indication that she will consider interim recommendations as that feels to me to be an important aspect of making urgent changes to safeguard patients now.

21.3. I have felt quite unassured listening to the evidence of the Trust to date. My concern is that the evidence I have seen so far suggests that the Trust does not fully grasp the seriousness of the situation in Essex. This raises concerns about their ability to address it.

21.4. In my view there should be a central record of all deaths and near misses in mental health settings.

21.5. I support the submissions of INQUEST that there should be a national oversight mechanism which is independent and can properly scrutinise the

implementation of recommendations. I echo the concerns that Deborah Coles, INQUEST, raised during her evidence to the Inquiry that the current situation is such that it is possible for recommendations to be made but not implemented, which means that opportunities to make mental health settings safer are missed, and also results in a waste of public money when adverse situations are permitted to recur. I understand that a national oversight mechanism as proposed would involve collating proposals for change, analysing the responses of public bodies and following up on progress, escalating concerns and sharing thematic findings so that changes to improve patient safety would be effective.

21.6. Ms Coles also stated that the ability and capacity for the families to grieve is affected by the very situation the death has occurred in, because for instance, mental health care providers might hold documentation that allows the fullest understanding of how someone's death came to happen. In my experience other factors specific to these sorts of situations also affect the ability to grieve, including for example, moral injury resulting from challenges to assumptions one holds about the behaviour of healthcare or state institutions; one's sense of injustice being compounded by relevant parties' behaviour occurring after death and/or revelations about behaviour contributing to it; the onus being placed on families to hold people to account at a time when they might be reasonably understood not to be best placed to do so. I invite the Chair to consider making recommendations that might alleviate some of the burden placed on bereaved families, in particular because it seems likely to me that this goal is compatible with improving patient safety, which should be this Inquiry's primary concern.

21.7. Families should have equality of arms with Trusts in inquests including through legal representation and disclosure processes.

21.8. Families are in a position of being the best placed to understand and help their loved one and this should inform aspects of patient care. The involvement of family members is a core part of clinical decision making and NICE guidelines. It worries me that my parents were not told about Ed's previous ligature until they saw the SUI panel investigation. They could have advocated for him and certainly would have raised concerns about his belt being returned to him had they been in full possession of the facts. Knowing them as I do, I assume that would just have offered to buy him a better-fitting pair of trousers and to bring them to the ward.

21.9. Institutional defensiveness appears to have contributed to reduced patient safety. I look to the Inquiry to make recommendations to address staffing and culture, so that staff are aware of the possible consequence of their actions for future patient safety.

21.10. I would welcome recommendations that properly address implementing whistleblowing safeguards and end the use of reprisals against whistleblowers.

21.11. There appears to me to be scope for recommendations about CAMHS and transfer to adult services. The communications, care planning, discharge and liaison with families all appears to need improvement.

21.12. The facts of Ed's care give rise to concerns about commissioning processes. I would welcome the Inquiry investigating this area further if they consider it to be of wider concern given the experiences of other patients.

21.13. In her opening remarks to the April/May hearings, the Chair stated that the Inquiry is minded to investigate the extent to which all suicides are preventable. I think that this is an important undertaking and I would welcome to the opportunity to engage with the Inquiry on this matter in the future.

21.14. I hope that these observations are of assistance to the Chair at this stage and I am available to provide any further information as needed.

Statement of truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth

Signed

[I/S]

Dated 27th May 2025