IN THE LAMPARD INQUIRY

Witness Name: Catherine Peck
Statement No: 1
Exhibits: Nil
Dated: 5 June 2025

FIRST WITNESS STATEMENT OF CATHERINE EDNA LILIAN PECK

I, Catherine Edna Lilian Peck, will say as follows:

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 24 February 2025.

Background

1. I am the sister of Richard Harland Elliott ("Richard"), deceased, who was born in Southend on 1 December 1953. We were eight siblings (six brothers and two sisters). Richard was the second eldest sibling and eldest of the boys. I am the eldest sibling. We grew up in Colchester.

2. I have already provided a commemorative statement to the Inquiry which includes the fact that Richard had for many years advocated on behalf of mental health service users, writing many letters and articles. He wanted to change the way patients were treated and lobbied for reform.

3. Richard was 48 years old when he died on 24 May 2002, when he was an inpatient on Peter Bruff Ward at Clacton Hospital (run at the time by North Essex Partnership University NHS Foundation Trust ("NEPT")).

4. In preparing this statement, I have had access to and reviewed Richard's community medical records which date back to 1989. I have also had access to Richard's own contemporaneous notes about his illness and treatment, which he kept throughout his periods of illness. I will refer to these documents where relevant in order to best assist the Inquiry in providing as much information as possible about Richard's care and treatment.

Diagnosis

Richard's first illness and contact with mental health services

5. Richard emigrated to Canada with his wife in his twenties; his medical records note that he emigrated in 1980. My understanding is that, before moving to Canada, Richard had no history of mental illness, and he had been considered fit to emigrate there. Richard first became unwell whilst he lived in Canada. Richard and his wife divorced

around 1982. I recall that Richard was affected badly by the divorce. He spent all his savings on accommodation, and he had to rehome his two pet dogs. He worked in a nightclub, first as a doorman and later as manager. He sofa surfed with friends.

6. I believe that, whilst with some new friends, Richard ate some pizza which had been laced with hallucinogenic drugs and whilst under the influence of these drugs, it is my understanding that he wandered into a restricted area of a military facility and that he refused to leave. He was arrested and taken to a hospital where he was detained, having been assessed as mentally unwell.

7. Richard's medical records from this period note that '*the first admission to hospital was in Canada when a diagnosis of schizophrenia was made*'. My understanding is that his treatment in Canada included electroconvulsive therapy. I understand that he had several sessions of electroconvulsive therapy.

8. Our family knew nothing about Richard's illness and treatment in Canada until our family was contacted by a Canadian doctor who advised my parents that it was in Richard's best interests for him to be brought back to the United Kingdom ("UK"). Our parents subsequently arranged for Richard to fly back to the UK.

Progression

9. Over the years, on return to the UK, Richard continued to have episodes of severe mental illness for which he was hospitalised. Admissions would usually last for a few weeks until he was well enough for discharge. Richard's medical records note that he had six hospital admissions between 1985 and 1995. Please see the below table summarising Richard's inpatient admissions prior to the relevant period:

Summary of Admissions Prior to the Relevant Period

Admission Dates	**Hospital(s)**	**Relevant Excerpts from Mental Health Records**
1987	Severalls Hospital	*Several previous admissions to Severalls Hospital, the last one in 1987.*
21 June 1989 to 18 July 1989	Severalls Hospital	*Richard had been picked up by the police on the previous day and had been described as acting strangely. He had apparently been pushing his car into the centre of the road. He was seen by the GP and a police officer and admitted informally to Severalls [...] In the interest of safety of others he had been placed in seclusion. He was relatively calm but very deluded and thought disordered [...] struck out at Nurse.*
23 October 1992	The Lakes Mental Health Centre, Severalls Hospital	*Diagnosed as suffering from manic depressive psychosis [...] Hso of aggression & sexually uninhibited behaviour. Has previous attempted to absent himself from ward when detained under s2. Admitted this morning due to relapse of mania. Has been aggressive & has attempted to leave the unit.*

13 February 1995 to 3 September 1995	Willow House Secure Ward, Severalls Hospital The Lakes Mental Health Centre, Severalls Hospital Peter Bruff Ward, Clacton Hospital	*In the previous few weeks he had stopped taking medication and his relatives said that he had become increasingly active, suffered disturbed sleep and began developing bizarre thoughts. Immediately before admission he had visited the District General Hospital and tried to pass himself off as a Telecom Engineer.* *Richard was admitted informally between 13/2/95 and 27/2/95. He was re-admitted on 31/3/95 informally [...] He was treated with major tranquillisers and his condition appeared to rapidly resolve. He was allowed brief periods of leave which were successful. I [Dr [I/S] Consultant Psychiatrist] was cautious however, as it had been noted in the past, that although Mr Elliott's condition rapidly responds to treatment, he can also relapse rapidly suggesting than an improvement is not as secure as it appears. His condition remained stable however and he was discharged from Section III by my colleague during a period of my annual leave.* *In April of this year he was discharged from section although he remained in hospital. Thereafter he did not take the prescribed medication and as a result there was a rapid relapse, and he was again sectioned in May [...] [he] had to be detained under Section 3 on 22/5/95. [...] Following an attack on a member of staff at the Lakes [...] Richard was transferred to Willow House, a secure unit, for more intensive treatment where he remained until 16/6/95, transferring back to the Lakes Unit [...] where once again he became hostile, threatening and aggressive towards staff members [...] and subsequently transferring to Peter Bruff Unit in Clacton on 20/6/95.* *He is prescribed:* *Haldol depot 200mg IM every four weeks* *Chlorpromazine 200mg t.d.s* *Lorazepam 2 mg oral or IM up to twice a day if required for disturbed behaviour.* *He refuses to accept oral Haloperidol.*
Circa March 1996	Not known.	*His most recent period in hospital ended in March 1996.*
24 January 1997 to 25 February 1997	The Lakes Mental Health Centre, Severalls Hospital	*[Richard] was apprehended that night having gained entry into the Coast Guard Station at Walton on the Naze at 1am on 24 January 1997.* *Exhibits [...] thought disorder and delusion [...] declined the treatment advised. Has become severely ill over the past 24 hrs and is now agitated and verbally aggressive. He is a danger to other people if not detained. [...] Pt suffers from hypomania. His condition is deteriorating and he's refusing treatment. [...] He is disinhibited, grandiose and displaying flight of ideas. [...] Mr Elliott has no insight into his condition, he does not believe he's*

		ill, is adamantly refusing medication and has history of non-compliance when out of hospital. *Initially interviewed Mr Elliott [...] with police officers quite close. [...] At the conclusion of the interview, Richard told Dr* **[I/S]** *that he would kill him if he was placed under Section. He said that his ambition was to go through life without killing someone. When I* **[I/S]** *Social Worker] told Richard later that he was subject to Section 3, he became aggressive and attempted to leave the hospital. To enable the medical team to administer an injection, the assistance of the police was required.*
22 April 1997 to 20 May 1997	The Lakes Mental Health Centre, Severalls Hospital Peter Bruff Ward, Clacton Hospital	*Mr Elliott was detained by police under s136 for acting in an unusual way outside Colchester Police Station in the early hours of the morning. Events began late on 21.4.97 when Mr Elliott persistently phoned the coastguard service, saying he was in a sinking yacht. [...] he has a diagnosis of manic-depressive psychosis. [Richard is] showing flight of ideas, abnormal thoughts and it is not possible to hold a sensible conversation with him. He presents with symptoms typical of a hypomanic episode. [...] The present method of treatment (lithium carbonate) is not working and he has deteriorated significantly [...] he refused to go into hospital voluntarily [...] he is also refusing to take medication [...] [he] is likely to cause disturbance if left to his own devices.*
14 June 1997 to 12 August 1997	The Landermere Centre / Peter Bruff Ward, Clacton Hospital	*Richard was referred by his parents who were concerned that he had not been taking his medication and was becoming increasingly unwell. [...] Having previous acquaintance of [redacted] I* **[I/S]** *Social Worker] knew how important it was to co-ordinate our assessment as on a previous occasion he had absconded before the interview could take place. On this occasion the Consultant, GP and myself, with two police officers in attendance, co-ordinated our approach to Richard's house. [...] [Richard] was expressing very imaginative, psychotic ideas. Rambling thoughts, incoherent ideas, slightly aggressive and intimidating attitude to all of us. His language was quite offensive. [...] Richard would not agree to go to hospital as an informal patient. Taking into account all of the circumstances, particularly the need for Richard to receive treatment, and the danger that he was placing himself and others in, continuing to drive his car, we concluded that the only appropriate action was admission to hospital, following the completion of a Section 3 application.*
4 November 1997 to 11 December 1997	Ardleigh Ward, The Lakes Mental Health Centre, Severalls Hospital	*Mr R Elliott was detained under Section 3 of the Act. [...] Referred by Police Dr* **[I/S]** *. [...] Police had picked up Richard [...] after a very dangerous episode of driving – on A133 – 96mph – overturned and travelled 75 years on road. [...] called in Police Surgeon – Dr* **[I/S]** *– who requested M.H.Act assessment. [...] Richard has left his car and virtually 'hijacked' another car insisting driver (a woman) take him home. [...]*

		Richard was banging on neighbours doors unable to get into his home – keys left with car. [...] [Richard] has been on anti-psychotic medication since June but family never sure whether he's taking medication. They feel he goes very quickly when he deteriorates. Since leaving his parents address to live independently there is no monitoring of his medication. He does not have close contact with community services – does not attend Day Hospital / Centre etc – so early indications of a deterioration are not picked up. Mother thinks he needs close supervision / support. [...] He had been physically trying to shut the three policeman attending him out of the interview room – he is a large man and would require a lot of physical restraint. Richard was escorted from the room by the Police – his mood is volatile and unpredictable. [...] Many staff on the Ward, CMHC know Richard well. When well, charming and pleasant but can be very violent. Has seriously assaulted a member of the ward staff in the past and when manic can be aggressive and hard to manage. [...] A close monitoring Care Plan needs to be organized prior to discharge or non self-medication. [...] Patient is disinhibited, overfamiliar and has elated mood. He has been diagnosed with bipolar affective disorder. [...] Patient is not willing to comply with medication and requires inpatient treatment in order to protect himself and other persons.
2 February 1998 to 15 May 1998	Peter Bruff Ward, Clacton Hospital	*Mr R Elliott was detained under Section 3 of the Act. [...] Referred by [...] mother. [...] Mental Health assessment on Friday 30./1/98. Since this time condition and situation has continued to deteriorate. Today he left home address leaving very loud music playing and doors to flat wide open. Visited parents. He became verbally abusive and threatening in manner. Returned to home address with mother. He took oral sedation and slept [...] when he woke up behaviour became threatening, verbally abusive towards mother, displaying little insight into situation. Mood and behaviour very changeable [...] elated in mood and gave some evidence of paranoid thoughts [...] Clearly this man is very disturbed and unable to give any informed consent. He does not want to be admitted to hospital [...] He has an established history of manic depressive psychosis with recent relapse of a hypomanic illness with sleep disturbance, agitation, verbal hostility, disordered thinking, impaired judgment and insight and unpredictable behaviour. [...] Outpatient treatment has proven ineffective.*

10. On his return to the UK, Richard lived with our parents as he was unable to cope independently. Richard later described that, on recovering from his first episode of mental illness, it was as if he had been a toddler and he had had to "grow up" all over again. He had to re-learn daily living activities (for example, how to feed and dress himself) and he had to re-learn how to hold a conversation. Richard's condition initially improved and he returned to working for British Telecom.

11. From memory, Richard's first relapse took place in 1987, after he began to exhibit strange behaviour whilst at work (see paragraph 28 for further detail). I remember that he went on sick leave from British Telecom and that he subsequently lost his job. Richard's personal notes state that he had stopped working for British Telecom by 1988. Thereafter he received an incapacity pension and invalidity benefit.

12. When Richard was discharged from the hospital following a second relapse, he appeared to be over-medicated, and he was barely functioning. Richard's medical records indicate that this second relapse took place in June 1989. Richard's personal notes state that he was receiving depot injections in 1989. The depot injections were slow release, but the effects had the greatest impact within the first few days following administration.

13. Richard subsequently obtained another job. Richard's personal notes state that he was working for Astralux Dynamics ("Astralux") in around 1991. I remember that Richard worked for Astralux whilst still living with my parents. The company was based in Brightlingsea. I recall that Richard was being given depot injections whilst he worked there. Richard was able to drive to work, but I remember that he was exhausted, and he slept a great deal. He went to work, ate, and slept; that was all. He struggled to participate in conversation; he could just listen to the conversation and would only respond if he had time to gather his thoughts. I recall occasions when Richard was slurring his speech and drooling when he talked. Richard stopped working at Astralux; his personal notes state *'1991 - worked at Astralux - gave up - high dose*'. This experience resulted in Richard ceasing his medication, which he called a 'chemical straitjacket'. Whilst there appear to be no records available from this time relating to Richard's medication and its effects, later records demonstrate the effects that the different prescribed antipsychotic medication had on Richard over the years, for instance:

    a. Richard prepared a letter entitled "*Help wanted. They're killing me and my friends*" on 17 July 1994. He wrote *'Psychiatric medication takes its toll on the body, as well as the mind [...] he struggles daily with a mental health problem, which drains his physical strength. This person is so doped up he finds it difficult to take care with personal hygiene and hasn't had a decent home cooked meal for years. Because once, years ago, because of his stout physical stature, he was put on a torrid regime of major tranquilisers to subdue him'.*

    b. Richard's medical records note that on 2 July 1998, he reported that his depot injection medication was making him drowsy. On 4 November 1998, he again reported that the 250mg Clopixol depot injection was making him sleepy. Records report that his dosage was reduced to 200mg in around December 1998. Records from January 1999 report that he was subsequently '*brighter in his mood. Sleeping much better and getting up at a reasonable hour. Going out more; self care has improved; taking a good diet via Meals on Wheels'.*

c. On 13 April 2000, during the relevant period, Richard's GP reported that Richard appeared *'flat and showed some Parkinsonian side effects from his depot injections. He says that for two weeks after his injection he suffers from stiffness of his muscles and tremors'.*

d. On 9 May 2001, Richard '*complains side effects of sodium valproate [...] made him punch drunk shortly after taking it'.*

14. Richard lived with my parents until around 1994; he then moved to a flat on Greenstead Road, Colchester, where he lived alone. He moved so that he could live independently.

15. Richard moved to a flat in Dovercourt, Harwich around June 1999; Richard's records note that he moved to Harwich as he was able to get better value for money, as he moved from a one-bedroom flat to a two-bedroom flat. His records also indicate that Richard wanted to place some distance between himself and his family. Our parents would often try to seek assistance from health services for Richard when his condition deteriorated, though I think Richard felt that they were over-reacting to every "sign" that he was becoming unwell again. I believe that he wanted to have greater control in respect of his care and treatment. Having moved to Dovercourt, Richard remained in contact with myself and the rest of the family. We would speak in person and over the telephone. I went from seeing Richard in person once per week to around once per fortnight.

Dates of diagnoses

16. I believe that Richard's first diagnosis was made in Canada, where he was told that he had schizophrenia. When he returned to the UK, this was later revised to manic depression, now known as bipolar affective disorder. To my knowledge this diagnosis was initially provided by staff at Severalls Hospital in Colchester. This is the extent of my personal knowledge regarding Richard's diagnoses; my parents may have been given more information as Richard's next of kin.

17. Richard's medical records note the following:

a. A social circumstances report prepared by **[I/S]**, Social Worker, dated October 1992, states that Richard was *'Diagnosed as suffering from manic depressive psychosis'* and that the *'1st episode [was in] 1985'.*

b. A report prepared by Dr **[I/S]**, Consultant Psychiatrist, dated 22 June 1995, notes that Richard's *'first admission to hospital was in Canada when a diagnosis of schizophrenia was made. All the subsequent admissions, however, have been characterised by grandiose delusions and behaviour and the diagnosis has been one of manic depressive disorder (manic type)'.*

c. Richard's EPUT mental health notes record the following diagnoses –
   i. Schizophrenia;

ii. Bipolar affective disorder;
iii. Paranoid personality disorder; and
iv. Acute and transient psychotic disorders.

18. From my experience, Richard didn't generally display any symptoms of depression, but did have manic periods where he would have elevated levels of energy; he would be talkative, active, and excited. His mind wouldn't rest. He also experienced sleep disturbance and he would sometimes appear unkempt.

Assessment and admissions

Requests for mental health assessments

19. My parents, Colin and Barbara Elliott (both deceased) would often try to seek assistance from health services for Richard. Richard's medical records note that *'Richard was referred by his parents who were concerned that he had not been taking his medication and was becoming increasingly unwell'* in June 1997. Another record shows that an assessment under the Mental Health Act 1983 ("MHA 1983") took place on 30 January 1998 after my mother referred Richard to community mental health services. The records state that he had left his home address leaving music playing loudly and his flat door open, and that he was *'verbally abusive and threatening in manner'*. His mood was reportedly '*changeable*'; he was '*elated in mood and gave some evidence of paranoid thoughts*'.

20. I recall that there were sometimes delays in getting Richard assessed. My parents would have to contain him to keep him safe and trick him into staying in the house until the mental health professionals arrived. I remember one occasion where my mum stayed at Richard's flat, staying awake, for two nights to keep him safe whilst awaiting an assessment. To my knowledge, my mother never feared for her safety or ever felt threatened by Richard.

21. On other occasions, Richard was referred to hospital by a police doctor or surgeon. For example, on 4 November 1997 Richard was referred for a mental health assessment under the MHA 1983 by Dr [I/S], who is described in the records as a 'police surgeon', after he was detained by police following a dangerous driving episode. On 7 August 2001, Richard was similarly referred for a Mental Health Act assessment by Clacton Police following their contact with him whilst in a state of apparent crisis; extracts of records regarding this subsequent inpatient admission are provided below at paragraph 29.

Reasons for mental health assessments

22. I remember that when Richard relapsed, he would have symptoms of mania including distorted thinking, paranoia, confusion, and he would be very talkative. He would also experience sleep disturbance. Though never personally witnessed by myself, my mother told me that Richard could also become disinhibited. When Richard presented

with these symptoms, it often led to a request for assessment under the MHA 1983 being made, either by my family or mental health professionals involved in his care.

23. Sometimes Richard was persuaded to go to hospital with my parents, and he would be informally admitted, but sometimes he was sectioned under the MHA 1983.

24. Assessments were usually carried out in an emergency or crisis situation rather than as part of a routine assessment or as part of ongoing care and treatment in the community. Richard's relapses always seemed to progress very rapidly to a crisis point, within about three days or so.

25. Records relating to Richard's admission to The Lakes Mental Health Unit, between November and December 1997, state that *'[Richard] does not have close contact with community services - does not attend Day Hospital / Centre etc - so early indications of a deterioration are not picked up. Mother thinks he needs close supervision / support'.* I believe that it was around this time that Richard started having more involvement with service user groups. The medical records indicate that Richard was open to the community mental health services, throughout the duration of his illness in the relevant period, including the provision of psychiatric outpatient appointments at Martello Court, a programme of activities at the Mayfield Day Centre and reviews with his Care Coordinator. It appears however that the frequency of Richard's engagement with these services varied.

26. To my knowledge, the only procedure recommended to our family, when Richard's mental health appeared to be deteriorating, was to call the emergency or crisis services for help so that medication could be given in a 'safe' environment in a secure hospital. This was the case both before and during the relevant period. This is demonstrated within Richard's medical records where it is stated, for instance, that on 21 May 2002 my mother called the 24-hour service team and Richard's girlfriend called Healthcall to share their concerns regarding his worsening condition and non-compliance with medication.

27. My parents were present at some of Richard's mental health assessments. I have no knowledge of what was discussed during the assessments or what follow-up steps were planned outside of what is detailed within Richard's mental health records.

Richard's first relapse

28. From memory, Richard's first relapse took place in 1987. This first relapse occurred whilst Richard was still working with British Telecom. I recall that there had been a strike at British Telecom; Richard did not take part in the strike as he was still on probation at that time, and he was consequently victimised by some of his colleagues. He subsequently relapsed and this led to his admission to Severalls Hospital. All of Richard's siblings, including myself, attended a meeting with Richard's doctor whilst Richard was on the ward in hospital. We went to find out what was happening and to

see how we could help Richard. We requested some kind of counselling or talking therapy for him. We were however told mental illness was not treated in this manner, and that they only treated patients with medication. I do not recall this being a lengthy admission. Richard was discharged and he subsequently continued to live with our parents, and he returned to his employment with British Telecom. Richard's medical records note the following:

'Nineteen-eighty-seven was a very stressful year for Richard. He found himself in an industrial dispute between Telecom and his Trade Union and throughout this dispute, Richard worked. Richard became mentally ill again and had to be hospitalised. This illness caused the breakdown of a relationship with his girlfriend'.

Admissions during the relevant period

Admissions before 23 May 2002

29. Richard's medical records provide the following detail regarding his admissions during the relevant period:

Admission Dates	**Hospital(s)**	**Extracts from Medical Records**
25 July 2000 to 17 August 2000	Peter Bruff Ward, Clacton Hospital	*Community [...] 24/07/2000 [...]* **[I/S]** *[...] Following pc from* **[I/S]** *at Monday group, called to see Richard who may be deteriorating mentally. Called to group. Presentation: less well kempt than usual, wearing more torn clothes. Aloof. Clearly suspicious that I had attended group, able to sit separately with him for short period of time. Speech content is bizarre, disconnected often from conversation. Paranoid element clear – made him cup of tea, concerned that I may have put drug in it; telling me that my menthol cigarettes don't have menthol in them. States he feels alright, doesn't know why I am here, wanting people to leave him alone. Expressed my concern particularly since he has stopped IMI, questioning if he felt he needed to be in hospital – refused idea. Element of hostility in him, asked what he had in back pocket – 'none of your business'. Impression that Richard may well be deteriorating, becoming more psychotic although no florid hypermanic symptoms observed at present. Record of receipt of medical recommendation(s) and formal admission to hospital [...] admitted to this hospital on 25/7/00 [...] formally detained under section 3 on 25.7.00.* *Application by approved social worker for admission for treatment [...] Presented bizarrely while attending day care*

		seventeen miles from his home. GP unable to attend. Police surgeon saw him as sect 136. *Joint medical recommendation for admission for treatment [...] We Dr* [I/S] *[...] [and] Dr* [I/S] [I/S] *[...] registered medical practitioners, recommend that Richard Harland Elliott [...] be admitted to hospital in accordance with Part II of the Mental Health Act 1983. I Dr* [I/S] *last examined this patient on 25th July 2000. I Dr* [I/S] *last examined this patient on 25.07.2000.* *Has relapsed again and is presently in a schizo-manic state, detained on s.136 at [...] police station. He is [...] agitated, disinhibited and has disjointed speech. Has stopped his depot injections 2 months ago which has led to this relapse. [...] He is very psychotic and has little insight. Refuses admission and treatment with medication. He is too uncooperative and disruptive to consider any community treatment.* *Community [...] 09/08/2000 [...]* [I/S] *[...] seen in review at PBU. Reported to be very well at present although he complains of excess sedation. Droperidol stopped as result. Keen that he should not have to take carbamazepine. Due to attend family wedding this weekend, granted leave over weekend to return to ward on Monday. Plan to lift section next week and plan discharge.*
6 September 2000 to 20 September 2000	Peter Bruff Ward, Clacton Hospital	*Community [...] 06/09/2000. [...]* [I/S] *[...] As duty officer I was made aware this am of some concern regarding Richard's behaviour towards a female fellow Wit's End member who presented at the center and expressed her distress to* [I/S] *It was decided that* [I/S] *and myself would attend the group to assess the situation. Pc received from Pavillion caretaker just before our departure to same expressing further concern Richard who was presenting as 'threatening'. We found him to be invading personal space, threatening behaviours and talking inappropriately, exhibiting flight of ideas and delusional beliefs/thoughts. This was reflected back to Richard by myself and reinforced by peer group members who expressed their concern for him. At one point Richard said he felt low in mood. Finally he agreed for me to escort him to PBU where I understood a bed was to be available to him.*

		[I/S] *requested police to transport and they obliged immediately. Richard was informed that we were not going by taxi and some anxiety was apparent when he saw the car, reassurance that admission would be with dignity if he could behave appropriately. We arrived at the unit without incident at 12.30 hrs and Richard was seen promptly by RMO. I understand Sec 3 MHA was being applied for as I left'.* *Record of receipt of medical recommendation(s) and formal admission to hospital [...] admitted to this hospital on 6-9-2000 [...] formally detained under section 3 on 6.9.2000. [...] The patient's nearest relative was informed of the patient's admission on 6-9-2000. .* *Medical recommendation for admission for treatment [...] I Dr* [I/S] *[...] a registered medical practitioner, recommend that Richard Elliott [...] be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983. I last examined this patient on 6.9.00. [...] He has an established diagnosis of schizophrenia and has relapsed. It is known that he is dangerous when unwell. He has gross thought disorder and delusions. [...] He refuses to accept medication despite negotiation. He is deluded that medicine is unnecessary. He is too dangerous to be in the community. It has been shown that his illness responds best to zuclopenthixol, but he refuses this.* *Medical recommendation for admission for treatment [...] I Dr* [I/S] *[...] a registered medical practitioner, recommend that Richard Elliott [...] be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983. I last examined this patient on 6th September 2000. [...] He has an established diagnosis of schizophrenia and is in a relapse (due to stopping medication). He has a past history of aggressive and dangerous behaviour in this situation. He has thought disorder and delusions. [...] He tends to refuse medication (although he has taken one due prior to my assessment). He cannot agree to taking medication and is not happy on the [illegible]. He has been completely out of control rapidly in the past.* *Application by approved social worker for admission for treatment. [...] I* [I/S] *[...] hereby apply for*

		the admission of Richard Elliott [...] for treatment in accordance with Part II of the Mental Health Act 1983 as a person suffering from mental illness. I am an officer of Essex County Council. [...] I last saw the patient on 6th September 2000. *Approved social worker assessment social circumstances report [...] Deterioration in mental state in community over last 48 hrs. [...] Diagnosis – schizo affective disorder. Mr Elliott does not take medication regularly. Discharged 17th August 2000 – very well when discharged. Mr Elliott's behaviours have become bizarre and mood aggressive [...] pattern of deterioration in the community. [...] Unable to contact [nearest relative]. Left [...] message informing that I had made application for detention under sec 3 MHA – suggested that they phone Peter Bruff Unit.* *Interview Mr Elliott with* **[I/S]** *[...] 2 nurses present due to risk of aggressive behaviour. Mr Elliott was cooperative [...] Thoughts disjointed, flight of ideas [...] Detention appropriate to treat mental illness and prevent further deterioration. Made application for detention under Sec 3 MHA 83.*
27 February 2001 to 7 March 2001 7 March 2001 to 28 March 2001	Clacton and District Hospital	*Record of receipt of medical recommendation(s) and formal admission to hospital [...] admitted to this hospital on 27.02.2001 [...] the patient was consequently formally detained under section 3 on 2/3/01 [...] The patient's nearest relative was informed of the patient's admission on 2.03.2001.* *Medical recommendation for admission for treatment [...] I Dr* **[I/S]** *[...] a registered medical practitioner, recommend that Richard Elliott [...] be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983. I last examined this patient on 27th February 2000. [...] This pt with a long history of schizo-affective psychosis has relapsed again. His speech is disjointed and incoherent and is disinhibited in behaviour. Has no insight and does not consent to voluntary admission. Currently detained on sec 136 at Clacton Police. [...] This pt had several previous admissions under section and due to lack of cooperation it is difficult to treat him as an outpt. Now requires urgent inpt treatment.*

		Medical recommendation for admission for treatment [...] I Dr **[I/S]** *[...] a registered medical practitioner, recommend that Richard Elliott [...] be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983. I last examined this patient on 27.02.01. [...] Severely disturbed mentally; disjointed speech, no comprehension of routine questions, no insight into problems. Known schzo-affective disorder. [...] Will not consider voluntary admission. Cannot realistically be treated effectively in the community as won't cooperate. Requires admission.* *Application by approved social worker for admission for treatment. [...] I* **[I/S]** *[...] hereby apply for the admission of Richard Elliott [...] for treatment in accordance with Part II of the Mental Health Act 1983 as a person suffering from mental illness. [...] I last saw the patient on 2.3.01.*
8 August 2001 to 26 September 2001	Severalls Hospital	*Record of receipt of medical recommendation(s) and formal admission to hospital [...] admitted to this hospital on 8th August 2001 [...] formally detained under section 3 on 9th August 2001. [...] The patient's nearest relative was informed of the patient's admission on 9th August 2001.* *Medical recommendation for admission for treatment [...] I Dr* **[I/S]** *[...] a registered medical practitioner, recommend that Richard Elliott [...] be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983. I last examined this patient on 8/8/01. [...] This man has a long history of schizo-affective disorder and is currently in a manic psychotic state with no insight. He is elated in mood, grossly thought disordered and is completely incoherent. Prior to coming into hospital he was diving dangerously at night without any headlights on. [...] He is a risk to himself and others due to his psychotic state and consequent behaviours. Needs urgent tranquilisers to control his behaviour and is unable to cooperate with treatment.* *Medical recommendation for admission for treatment [...] I Dr* **[I/S]** *[...] a registered medical practitioner, recommend that Richard Elliott [...] be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983. I last examined this patient on 08 August 2001 [...] Bizarre irrational behaviour. Caused a disturbance*

		earlier at house of female friend; then behaved in threatening manner on a public camp site where he was driving without lights at night- delusional and incapable of making any rational decision about his immediate management. *Medical recommendation for admission for treatment [...] I* [I/S] *[...] a registered medical practitioner, recommend that Richard Elliott [...] be admitted to hospital for treatment in accordance with Part II of the Mental Health Act 1983. I last examined this patient on 9th August 2001. [...] He is suffering from an acute relapsed of a known schizo-affective disorder. He is paranoid and violent and completely incoherent. He has attacked members of the public and staff whilst on the [illegible] [...] He responds to treatment which he is not able to consent to in his present state. He needs inpatient and probably parenteral treatment and long term follow up.* *Emergency application by an approved social worker for admission for assessment [...] I* [I/S] *[...] hereby apply for the admission of Richard Elliott [...] for treatment in accordance with Part II of the Mental Health Act 1983 as a person suffering from [...] mental illness.* *Approved social worker assessment social circumstances report [...] Referred by Clacton Police 7/8/01. [...] Open case of* [I/S] *CMHT. [...] Jointly assessed with police surgeon [...] No doubts about his mental state & need for admission. No second doctor available given time of night. [...] Long history of chronic mental illness with frequent relapses requiring admission usually in section. When in stable phase works as volunteer for Advocacy Service. [...] Richard quite thought disordered, talking in a very disjointed manner [...] clear that he needed to be admitted. Especially in conjunction with his well known history & recent reports to police & from parents. [...] Section 4 admission.*

30. Please note that EPUT have confirmed that they have provided my Recognised Legal Representatives with all of the records in their possession. This comprises only the community mental health records for Richard during the relevant period. I have not had sight of any other records, for example his inpatient records. His inpatient records for his last admission should have been made available to the Coroner. If not, that is a serious omission. They are certainly not in the bundle provided by the Coroner's Court.

31. As will be clear from the above summary, Richard's inpatient admissions in this period were characterised by his rapidly relapsing in the community, often associated with his refusal to take his antipsychotic medication. He would become very unwell, very quickly, presenting with bizarre behaviour and paranoid thinking. During these periods Richard would not recognise how unwell he was, or his need for treatment. On several occasions, I understand that he required detention by the police for his own safety, under s.136 of the MHA 1983, in order to ensure he could be promptly assessed and admitted to hospital.

32. By the time of the relevant period, Richard had developed a distrust of mental health services. My impression was that Richard had no confidence in the services' ability to properly care for and protect him. Richard felt that health professionals only wanted to control his illness with high doses of medication and sometimes lengthy admissions, rather than to treat the underlying causes. Richard had also told me about restraint used by Trust staff during his inpatient admissions within the relevant period (see paragraph 90 for further detail).

Admission on 23 May 2002

33. I have very limited information about the circumstances relating to Richard's final admission to Peter Bruff Ward at Clacton Hospital on 23 May 2002. I understand that EPUT has confirmed that his inpatient records have since been destroyed in line with retention policy. If this is correct, I am stunned that the records regarding Richard's admission between 23 and 24 May 2002 have been destroyed given the circumstances of his death.

34. Richard's last known GP practice and Primary Care Support England have also confirmed that they hold no records concerning this final admission.

35. As mentioned, EPUT have confirmed that they have provided my RLRs with all of the records in their possession. This comprises only the community mental health records for Richard during this period. There are only brief references to his admission to the Peter Bruff Ward on 23 May 2002, as follows:

'Telephone Contacts [21 May 2002]... Richard's mother contacted 24hr team expressing concerns that she felt Richard was deteriorating. Described behaviours that usually represent him becoming unwell. Felt that he wouldn't attend Mayfield Day Service. Richard's care co-ordinator is on leave until 5th June. Cpn **[I/S]** *went liaised with Mayfield Day Service, Richard had attended. They had no major concerns, although his shirt was dirty, which was out of character for him. He was stating that he was fine. However GP phoned later informing that his girlfriend had contacted HEALTHCALL, informing that Richard had stopped taking his medication. 4hr team liaising with Clacton Services'.*

'Joint medical recommendation for admission for assessment [...] We Dr [I/S] [I/S] *[...] [and[Dr* [I/S] *[...] registered medical practitioners, recommend that Richard Harland Elliott [...] be admitted to a hospital for assessment in accordance with Part II of the Mental Health Act 1983. [...] I Dr* [I/S] *last examined this patient on 23/5/02. [...] I Dr* [I/S] *last examined this patient on 23/5/02. [...] Richard has relapsed into a psychotic state. He is very hostile, paranoid and accused Dr* [I/S] *of committing burglary and threatened him with violent physical harm. Richard is not rational and has been accusing people of stealing his belongings. He produced a knife from his pocket which is very worrying'.*

'Application by approved social worker for admission for treatment [...] I [I/S] *of social services [...] hereby apply for the admission of Richard Harland Elliott [...] for treatment in accordance with Part II of the Mental Health Act 1983 as a person suffering from [...] mental illness. [...] I last saw the patient on 23 May 02'.*

36. Following the inquest into Richard's death, on 15 November 2002, a short 36-paged bundle of witness statements is all that I received from the Coroners' Court. Though I have not exhibited this documentation to my statement in accordance with the request from the Inquiry Legal Team, I urge the Inquiry to consider the Coroner's file in its entirety; the bundle contains key evidence regarding Richard's treatment during the admission which culminated in his death, and it is these events which have been of most concern and distress to myself and my family. No medical records were made available to me by the Coroner's service, despite my request for these; I do not know whether these were even requested or considered as part of the inquest process. The limited evidence from this bundle sets out the following sequence of events, as I describe below.

37. Richard's community Consultant Psychiatrist, Dr [I/S] was notified of his deterioration, in particular that he was presenting as increasingly disturbed. A 'Rapid Response Team' was assembled, comprising numerous police officers, the psychiatrist, a GP and a Social Worker, to attend his home. Richard was encountered as highly paranoid, making threats and accusing the GP of having burgled him. The decision was made to detain Richard under section 3 of the MHA 1983. Given concerns over a possible escalation in risk, it is recorded that police decided to assemble a 'Level Two entry', which appears to have meant convening numerous officers to effect his transfer to hospital.

38. I note that Richard's medical records state that, on 21 May 2002, my mother called the NEPT 24-hour service team and Richard's girlfriend called Healthcall to share their concerns regarding his condition. To my knowledge, none of my family members were subsequently contacted regarding Richard's relapse or planned sectioning. My understanding is that my parents had received a call from Richard's girlfriend on 23 May 2002, as she was concerned about him and requested that they accompany her to Richard's flat in Dovercourt. I am very concerned by the seemingly delayed response from the mental services to these events. I have seen no records to indicate

that, between our family raising concerns over Richard's deterioration on 21 May 2002 and the subsequent events on 23 May 2002, those involved in his care made any attempts to contact or assess Richard. For an acutely unwell individual, a delay of two days can be critical. If Richard had been assessed promptly, he may not have deteriorated to the point of crisis that he was in by 23 May 2002.

39. My mother told me that, when they arrived at Richard's flat, they saw the police presence outside and were told by a doctor that Richard was to be sectioned and transported to hospital. Fearing Richard would be forcefully restrained, my mum reasoned with him and told him that if he went with them voluntarily, he wouldn't get hurt. Richard was reluctant to go with to hospital, but mum spoke to him and calmed him down, persuading him to get dressed and go with the officers. He finished his second cup of coffee and got dressed.

40. In a witness statement provided to the inquest by PC [I/S], he reported that the officers were '*dressed in Mutual Aid attire*' (possibly in riot gear, this remains unclear) and that '*A police vehicle fitted with a security cage was requested*'. Richard complied and went voluntarily with the officers. A large number of police officers appear to have been involved in Richard's transfer and admission to hospital which appears to me to be heavy handed, frightening and inappropriate (see further below). On arrival at Clacton Hospital, the inquest evidence indicated that staff had to coax Richard onto the ward and redirect him away from other wards. It appears that, very soon into his admission (the inquest evidence available would suggest around 15 minutes) the decision was made to administer Richard two different antipsychotic medications (Acuphase and Haloperidol), together with a benzodiazepine (Lorazepam), via intramuscular injection. PC [I/S] described in his statement how Richard '*lay down on a mattress on the floor, again of his own free will. The staff removed his belt and lowered his trousers whereby a member of the staff placed an injection into his bottom, three times. Richard was still incoherent but remained in a calm manner. The staff then removed his tie and emptied his pockets. Richard was left face down on the mattress*'. PC [I/S]'s account aligns with this account, and they both state that Richard was '*left [...] alone in the room*'.

41. It appears that Richard was initially placed in overnight "seclusion" and was commenced on continuous observations, seemingly to monitor for adverse sedative effects from the medication. However, seclusion appears to have been terminated around 4-5 hours in, despite the fact he was observed to be highly sedated, non-conversant and repeatedly incontinent. After this point, it is unclear from the limited evidence I have seen what level of observations Richard was subject to, despite his unstable presentation. Witness evidence provided to the inquest by certain ward staff indicates that, at some point in the early morning, staff opened the 'side door' to the seclusion room, with the intention that a member of the nursing staff would be stationed outside to maintain observations. The evidence suggests that this resulted in other patients, sleeping nearby to the seclusion room, being moved by staff to the opposite end of the ward. I cannot understand why this was deemed necessary, nor

why staff considered it appropriate to leave Richard alone on that side of the unit in a seclusion room.

42. The available evidence indicates that, throughout the early hours of the morning of 24 May 2002, Richard presented again, several times, as incontinent and restless, requiring several staff members to change him. During further checks, he was observed to present with stertorous breathing and signs of sleep apnoea (which Richard suffered from). It is unclear what steps were taken to monitor his vital signs in this period or to maintain his dignity given his vulnerable physical state. It was only at around 05:20 that it appears staff noticed his breathing had quietened and entered to find his pulse faint and his lips blue. Emergency resuscitation efforts were initiated, however Richard passed away shortly after. His medical cause of death was recorded at the inquest as I (a) Congenital Anomaly of Left Anterior Descending Coronary Artery and II Left Ventricular Hypertrophy, with the Coroner concluding he died of natural causes. Given our unanswered concerns over the use of rapid tranquilisation, and the lack of proper observation, we simply cannot accept, without knowing more, that he died of "natural causes".

43. I cannot recall exactly when I became aware of Richard's admission to hospital on 23 May 2002. I remember receiving a call from my mother at around 8pm on 23 May 2002 to relay her account of the day's events. I remember her telling me that she had been distressed by the extent of the police presence at his flat and she told me that the officers had appeared to be wearing riot gear. She told me that she had persuaded the female police officers to allow her to convince Richard to comply and to attend hospital voluntarily in order to avoid a potential physical confrontation.

Developments in Richard's mental health

44. Every time that Richard was held in hospital, he became more disheartened. He became increasingly depressed about his circumstances. Each time he had to explain to friends why he had suddenly disappeared and had not been in contact, and why he had failed to fulfil commitments or appointments. He found it harder to prove he could be independent and to feel like a valued member of society. With each admittance to hospital, he became more despondent. Richard's depression would be followed by sleeplessness and inevitable manic behaviour. To us, as his family, he appeared stuck in a vicious cycle of relapsing illness, resulting in numerous inpatient admissions, which he could not break.

45. An entry from Richard's medical records from 5 September 2001 notes that he *'said that he was resigned to the mental health revolving door that he now found himself in - discharge, becoming ill, and re-admission'.* Records also state that, during a meeting on 22 September 2000, Richard discussed his feelings regarding admissions around that time. The record states that Richard felt *'stigmatised in this town, fears he may become known by local police as a "nutter".* Consideration was given to looking at how admissions could be facilitated without involving the Police; Richard was told that this

would involve him *'starting to see that relapse and hospitalisation is not a punitive process, and that he can himself seek feedback from myself or go to PBU seeking screening'*. Despite this, Richard's admissions continued to be characterised by rapid relapse and a reluctance to seek treatment, often requiring the intervention of the police, as well as crisis and acute mental health services.

Assessments that did not lead to admission

46. I am not personally aware of any occasions when Richard or others asked a mental health professional to consider admitting him and he was not admitted. However, Richard's community medical records detail a Mental Health Act assessment which took place on 18 April 2001 after services received a phone call reporting concerns that Richard was relapsing. Dr [I/S] saw Richard on 17 April 2001 in Clacton Hospital and completed a recommendation for detention under section 3 of the MHA 1983, after his care coordinator and support worker had reported signs of a relapse and probable non-compliance with his medication. Richard was subsequently assessed on 18 April 2001 by his GP, Dr [I/S] who was accompanied by a duty Social Worker and police officer. The records note:

'Richard assured us that he was taking his tablets and intended to keep his appointments at Martell Court Day Hospital. There were indications of thought disorder in some of Richard's comments and also inappropriate remarks at times. He became irritable, but no signs of verbal or physical aggression. I ensure that the police officer remained close to hand throughout the assessment. Richard assured us that his sleeping and appetite for food was fine. At times he blocked questions an also went off at tangents frequently. [...] Dr [I/S] [...] was not happy to sign a second medical recommendation on Richard's current presentation, despite his history and the knowledge that he relapses and becomes aggressive very quickly'.

47. Richard was not therefore admitted on this occasion. A corresponding entry from this assessment notes that the 'out of hours' team were informed of the decision not to admit, *'in case (client) causes havoc in the community'.* Richard was subsequently reviewed by Dr [I/S] and staff at Martello Court on 20 April 2001. At a review on 23 April 2001, Richard *'spoke about medication and felt [that it was] not at [the] right level in respect to kicking into his system'*. He was warned that, if he relapsed again, he would remain in hospital *'for considerable time and be placed back on depot medication'.*

Ward environment

48. When I went to visit Richard during his previous periods of inpatient admission, I only had access to the communal areas for visitors. As I only saw the visitors' area, I was unable to observe much in terms of how, or whether, the ward environment met Richard's basic needs. What I saw of the ward environment was 'okay'. It was generally pleasant. I remember the gardens at the Peter Bruff Ward being a welcome spot where you could almost forget it was a hospital.

49. In terms of Richard's reaction to being on inpatient wards generally, I think he resented the loss of liberty, of being told what to do and when to do it. I am aware that Richard often had his own room because his snoring disturbed the other patients.

50. I remember that Richard had the opportunity to take part in some craft classes. I am unsure whether these classes took place whilst Richard was an inpatient or an outpatient, but from memory they took place during the relevant period. I recall that Richard made a stool. He also wove a box for me and a heart-shaped one for mum.

51. I had no opportunity to visit Richard during his final admission to Peter Bruff Ward on 23 May 2002. As above, the first I was made aware that Richard had been admitted was late on 23 May 2002 when my mother phoned me to inform me of the events leading to his admission. I learned of his death the following day.

Staffing arrangements, training and support

52. The following Essex Trust staff members are detailed within the witness evidence as having been involved with Richard's treatment on Peter Bruff Ward between 23 and 24 May 2002:

    a. Duty Dr [I/S]
    b. Duty Dr [I/S]
    c. Dr [I/S]
    d. Duty Manager [I/S]
    e. Charge Nurse / Ward Manager [I/S]
    f. S/N [I/S]
    g. Staff Nurse [I/S]
    h. Staff Nurse [I/S]
    i. Staff Nurse [I/S]
    j. Staff Nurse [I/S]
    k. Staff Nurse [I/S]
    l. Staff Nurse [I/S]
    m. HCA [I/S]

53. Whilst I had no direct involvement with Richard's admission on 23 May 2002, the witness evidence raises for me serious concerns regarding staff training, competency and conduct on the ward, particularly in terms of the staff's rapid decision to sedate and seclude Richard, and the adequacy of their clinical monitoring whilst he was secluded.

54. I also have concerns regarding the nature and adequacy of the ward emergency response. Staff Nurse [I/S]'s witness statement provided to the inquest states that *'Dr [I/S] requested suction as his airway was possibly blocked, this equipment was brought from ECT suite, but the lead was found to be too short from the nearest socket in the lobby area. Richard was therefore moved using sheet towards the door'.* It greatly concerns me that important resuscitation equipment was not

seemingly fit for purpose. Staff Nurse [I/S]'s evidence regarding the escalation procedure for calling the Clacton Hospital 'crash' team also gives rise for concern: *'On being unable to get any response or tone of any kind I conferred with S/N* [I/S] *to ensure I was following the correct telephone procedure'.*

55. There appear to be no witness statements provided to the inquest from several key members of the ward staff, including from the staff nurse who discovered Richard unresponsive and raised the alarm, and who appears to have been the one responsible for observing him in the proximate period before his death. As I have already indicated above, I still do not know whether the Trust disclosed to the inquest proceedings the inpatient records from Richard's final admission to Peter Bruff Ward. I hope that the Lampard Inquiry will facilitate the provision of this important material, and any other relevant evidence concerning the circumstances of Richard's death.

Care management and plans

Involvement of family and loved ones

56. In a letter dated 12 June 1994, Richard wrote *'When family and friends receive their loved one back into the fold, they see a marked change in them. All that they are told is that it is the "illness" and they have done the right thing by taking them to the "professionals". The carers are purposely kept in the dark and know nothing of the "condition" except that their loved one is worse than when they went into hospital [...] The authorities must maintain a system of closer monitoring of psychiatrists with greater public accountability'.*

57. I was never directly consulted regarding Richard's care and treatment throughout the relevant period. To my knowledge, none of Richard's siblings or friends were ever informed or consulted about decisions relating to Richard's care and treatment. I believe that engagement with my parents was minimal.

58. Whilst I understand that my father was designated as Richard's Nearest Relative, and that my mother would liaise with the hospital and Richard's GP, I do not recall them being consulted or actively involved in Richard's care either.

59. Whilst my parents may have been involved with Richard's care and treatment, I am not personally aware of the extent of this. Records indicate that, during the relevant period, my parents were not always made aware of matters until after assessment and admission had taken place i.e., they were informed of the fact of detention as Nearest Relative, but their views on Richard's presentation and the suitability of admission were not consulted in advance.

60. A record of a meeting dated 23 April 2001, which took place shortly after a Mental Health Act assessment which determined that Richard would not be sectioned following concerns that he was deteriorating (see paragraph 46 to 47 above), states that *'Dr* [I/S] *also noted absence of parents and put to client their involvement in*

order to facilitate process. Client not receptive to these points at this time'. In a subsequent entry from 16 August 2001, during a period of inpatient admission, I note that Richard stated he wanted our parents to be *'shielded'* from the extent of his mental health issues, as *'he felt that they were now elderly and less able to cope with these matters now, though he appreciated their general support'.*

61. A record from 26 September 2001 details a CPA Review/section 117 Discharge Meeting which does not list my parents as attendees at the meeting, nor include any indication to suggest they were invited. Whilst it is noted as agreed that my parents could *'contact MH services GP if they felt Richard was becoming unwell',* there is no record to suggest that this information was relayed to them.

62. Whilst Richard was an inpatient, we were unable to contact him outside of visiting hours. I visited Richard around once per week whilst he was an inpatient. I would call the ward prior to visiting to make sure that he would be available. I remember Richard phoning me on a few occasions whilst he was an inpatient; I believe that he had to use the telephone on the ward to make a telephone call rather than using his mobile phone.

63. I only recall one occasion where our family was invited to provide input regarding Richard's care; this was shortly after his first relapse, as mentioned at paragraph 28. We provided some background information regarding Richard to the clinical team but were not consulted on how his treatment should progress. In fact, we suggested that seeing a psychiatrist for talking therapies would help, but this was dismissed outright.

64. When Richard was admitted to hospital in 1995, his medication was changed. It was too strong, and it stopped him from functioning. We informed inpatient staff of this; I spoke to a nurse who did not appear interested but said that she would relay the information that we provided. I do not believe that we were listened to, as no changes were made. I remember that I requested to speak to his treating doctor at the hospital but I was never given an appointment. Our family repeatedly raised concerns from early into Richard's admissions about his being overmedicated or wrongly medicated, but these concerns were consistently ignored or minimised.

65. I do not consider that I or my family were listened to when we attempted to provide our views regarding Richard's care and treatment. In my particular case, I had no say as I was not his designated Nearest Relative. I was not directly informed about any decisions relating to any aspect of Richard's care and treatment. Despite being his sibling, and having valuable information about Richard's history and presentation, my input was never sought (with the exception of the instance detailed at paragraph 63). When I requested to speak to his doctors, I was told that they were not available.

66. I also note that there are references to violent behaviour within Richard's medical records. My understanding is that my family was never made aware by NEPT of any violent behaviour exhibited by Richard whilst he was detained. We understood that he may have resisted administration of medication when initially admitted, but we were

never informed of any subsequent violence whilst on the ward. I was only aware of one instance where there was an altercation with a male nurse (which occurred prior to the relevant period) because Richard told me about this himself after we were refused permission to visit him during that admission. This was information which should have been shared with the family as it was relevant to Richard's care and treatment, especially to how we could support him safely in the community upon discharge.

Richard's involvement

67. Richard frequently felt as though he was being over-medicated. I am not directly aware of the extent to which Richard was involved with decisions relating to his care and treatment. Richard's community records indicate that some changes were made to his medication during the relevant period (see paragraph 70), these changes were prompted by Richard's requests rather than being as a result of a treatment plan. However, the records also indicate other occasions where Richard's concerns over his medication were not acted on by the treating professionals. I feel that this impacted on Richard's willingness to engage with the various mental health services involved in his care over the years, and on the steady deterioration in his mental health.

68. In a letter dated 17 April 1994, Richard wrote that "*Instead of taking the time to start a patient on a small dose and then gradually build it up, to achieve the required effect, they Whack the Patient with an extremely high initial dose and then forget to reduce it. It seems that they wish to shock the patient out of their trauma instead of nurse them through it*". I consider that the mental health professionals responsible for Richard's care should have offered to taper off his medication until he was functioning on a low maintenance dose. I also consider that Richard should have been offered frequent therapy sessions with a psychiatrist or clinical psychologist to talk about his traumatic experiences in Canada which had pushed him over the edge. Richard was aware of the benefits of talking therapies. in a letter addressed to **[I/S]** dated 4 August 1994, Richard addressed "*the need to provide inpatient psychotherapy counselling and homeopathic services*". In a further letter addressed to the Vice-Chairman of CHUMS, Richard stated that "*Community Care and therefore Social Services, is failing to meet the needs of the mentally ill [...] we are all individuals, who have different coping mechanisms and require differing forms of inpatient care [...] The inpatient services have failed to provide trained counsellors, psychotherapists and homeopathic therapists to help service users cope with their trauma. The Medical Model has failed to prevent users from having repeated admissions to hospital*". Richard wrote a poem entitled "Talking Treatments" in September 1994, as follows:

Please can you help me
I'm feeling quite distressed
I'd like to talk about it
Have my views expressed.

I've been to the medics
Who offered me some potions,

But these do nothing to
Help me with my emotions.

I suffer debilitating boredom
Now I've lost my career
I'm now in danger of losing
My family which I hold dear.

If I could tarry a while
In conducive surroundings
To gather myself together
Stop these heartbeat poundings.

You seem good for me
Someone caring for souls
Relief of repressed desires
Like a mare with her foals.

I like talking to you
We can communicate
I know you empathize
You are my soul-mate.

Now I have turned aside
From the physicians gaze
I can talk it through
Like acting out plays.

69. The above poem is demonstrative of Richard's commitment to advocacy work on behalf of mental health service users. In addition to his poetry, he wrote many letters and articles about the challenges that those with mental health difficulties face. He wanted to change the way patients were treated and lobbied for reform.

Treatment

Medication

70. The records show that modifications were made to Richard's medications during the relevant period. It is recorded that:

    a. At the start of the relevant period, Richard was prescribed Clopixol. A record from 13 July 1999 notes that Richard was prescribed Zuclopenthixol (Clopixol) injections every 4 weeks. A record dated 8 November 1999 shows that the Clopixol injection dosage was 200 mg.

b. On 13 April 2000, Richard requested a reduction of his Clopixol injections and Dr [I/S] agreed for this to be reduced from 200 mg IM every four weeks to 160 mg every four weeks.

c. Records note that whilst an inpatient on 9 August 2000, Richard was being given Droperidol ad carbamazepine. Richard complained of *'excess sedation'* whilst on the Peter Bruff Ward on 9 August 2000, and Droperidol was stopped as a result.

d. A letter dated 26 October 2000 notes that Richard was prescribed Clopixol injections 200 mg IM every three weeks. Richard complained at this time that he was experiencing side effects, namely frequency of micturition and poor sleep. He requested oral anti-psychotics and asked to be commenced on Quetiapine 100mg.

e. A letter dated 25 January 2001 reports that Richard was keen to be prescribed Quetiapine instead of the depot injections. This was agreed and he was commenced on Quetiapine 100mg tds and the depot was discontinued. A record dated 22 February 2001 notes that Richard experienced side effects whilst on Quetiapine, including sedation and feeling as though he had taken some alcohol. Dr [I/S] considered that this was 'a combination of sedation and slight postural hypotension'. Dr [I/S] continued him on Quetiapine 100mg and referred him to the Day Hospital.

f. A record prepared by Care Coordinator [I/S] dated 23 July 2001 notes that Richard's treatment at that time was 150mg Seroquel (i.e Quitiapine). Richard was also taking sodium semi-valproate.

g. A record prepared by Care Coordinator [I/S] dated 17 January 2002 notes that Richard was taking *'Olanzapine 15mg; Depocate – 500mg 3 times a day; Bendofluazide 2.5mg 1-2 tables daily – to reduce odema'.*

h. The report to the Coroner, prepared by Dr [I/S], states that Richard was given the following medication via intramuscular injections during his admission on 23 May 2002 –
    i. [I/S] Zuclopenthixol Acetate (Clopixol Acuphase);
    ii. [I/S] Haloperidol; and
    iii. [I/S] Lorazepam.

Talking therapies

71. I understand that, by the time of the relevant period, Richard had access to community group sessions led by a Nurse. His records note that, having relocated in 1999, Richard sought local support; he attended groups called Wit's End and 'the Monday group'. My understanding is that Wit's End was a support group for mental health services users. Richard was also a member of Colchester Health Users of Mental Services ("CHUMS"),

which was part of Colchester Mind, the mental health charity. I am also aware that Richard wrote poems and articles for a group called Linking Hands. He also attended Mayfield Day Centre.

72. To my knowledge, Richard never engaged with - or was offered - one-to-one therapy on the NHS before or during the relevant period.

Comments regarding treatment

73. I do not think that the mental health treatment provided to Richard was adequate or appropriate. In my view, prior to the relevant period, the treating professionals sedated Richard to the point that he couldn't function. I believe that it was not until towards the end of the 1990s, whilst Richard was living in Colchester, that a doctor suggested to Richard that he take a half dose of his prescribed medication to keep his moods stable, and I think Richard did try this; I recall my mother relaying this information to me and saying, "why has no one suggested this before?". Initially, prior to the relevant period, no talking therapies were offered to him to my knowledge, and my understanding is that mental health professionals generally considered that the only solution was to administer anti-psychotic medication to Richard in high doses. I consider that, had Richard been treated with talking therapies alongside appropriate medication (which could have gradually been reduced to a maintenance dose) from the beginning of his illness, he could have returned to his former life with very little disruption or stigma.

74. During the relevant period, though Richard appeared to function better than he had during the late 1980s to early 1990s (e.g., not struggling to converse), I still witnessed the side effects of his medication during this time; for example, I observed how he sometimes walked quite stiffly as a result of muscle rigidity. Whilst the records indicate that some changes were made to Richard's medication during the relevant period, these changes were prompted by Richard's requests rather than being as a result of a treatment plan. To my knowledge there was no treatment plan to attempt to reduce Richard's medication to a maintenance dose despite the concerns raised by Richard and his family.

75. I have particular concerns over the mental health treatment provided to Richard in relation to his final admission to Peter Bruff Ward on 23 May 2002.

76. From the limited evidence I have reviewed from the inquest, I have serious concerns over the use and appropriateness of restrictive measures used against Richard whilst on Peter Bruff Ward. In particular, the use of seclusion and chemical sedation.

77. Dr **[I/S]**, Consultant Psychiatrist, reported to the Coroner in his written evidence that Richard was placed in seclusion because *'Peter Bruff is an open unit, and [...] [Richard] was a very big and strong man with a proven history of physical violence against nursing staff'*. Dr **[I/S]** states that Richard was *'placed in seclusion in the first instance until he had calmed down'.* As described in the police evidence, Richard

attended the ward compliantly, without restraint. Whilst he is described as *'obstructive'* on first arrival at the hospital, there is no record of him acting violently or putting himself or others at risk. In their statement of 8 August 2002, Staff Nurse [I/S] states that Richard 'arrived at about 6pm' and, whilst he was initially 'unwilling to come into hospital', Richard's 'seclusion was commenced at 6.15pm'. It is distressing to read that Richard was heavily sedated and secluded so quickly into his admission, given the circumstances. I do not consider these measures to have been appropriate, particularly as PC [I/S] describes Richard as having 'remained in a calm manner' as staff treated him. I feel that on 23 May 2002 the ward staff placed undue emphasis on Richard's historical aggressive behaviours, which appeared to drive the pre-emptive decisions to sedate and seclude him, despite there being no record of him acting violently on arrival at the hospital.

78. I also struggle to understand why there was a need for a such a heavy police presence at Richard's house, in the period leading to his admission. Richard was acutely unwell and paranoid: the presence of so many officers, possibly in riot gear, would have only served to exacerbate his distressed behaviour. Whilst the records suggest he presented as initially unstable and agitated, he later calmed down, with the help of my mother, and was persuaded to attend hospital voluntarily, without restraint. The attending clinicians should have sought to provide Richard with therapeutic reassurance from the outset, rather than relying on the intervention of a police 'Rapid Response Team'. The involvement of so many police officers, it appears up to around 10, in the attendance and subsequent transfer to hospital, would have only made Richard more fearful of what was happening, and more likely to perceive his admission as punitive.

79. There are also concerns regarding overmedication. As above, it is noted that Richard was given [I/S] mg Zuclopenthixol Acetate (Clopixol Acuphase), [I/S] mg Haloperidol, and [I/S] mg Lorazepam via three intramuscular injections very soon into his admission to Peter Bruff ward. However, the toxicological bloods analysis, completed by Dr [I/S] [I/S] on 26 June 2002, appears to only have detected the presence of the benzodiazepine, Lorazepam, which was found to fall above the therapeutic concentration, just into the toxic range. Given that Acuphase and Haloperidol did not appear in the toxicology report, I am therefore unclear as to whether or to what extent Richard was under the effects of psychotropic medication at the time of this death.

80. As mentioned above, there are also concerns regarding clinical monitoring. Having entered the hospital of his own free will, Richard was rapidly sedated and secluded. He was clearly vulnerable. The witness evidence is unclear as to what steps were taken to monitor Richard's vital signs or presentation whilst in seclusion overnight, and I am concerned that the level of nursing observation was inadequate. I note that Staff Nurse [I/S]'s evidence states that *'During checks of the ward, Richard's condition remained the same – restless with stertorous breathing and sleep apnoea. At 03:30 [...] [Richard's] gold neck chains were observed to be tight and with some difficulty S/N* [I/S] *and myself assisted S/N* [I/S] *to remove some'*. It concerns me that no

senior clinician was called for an opinion or assistance, at the latest at this stage, considering that stertorous breathing was observed and that his jewellery was seemingly constricting his neck. By this point, Richard had also already presented as incontinent on several occasions. I am deeply concerned that the overnight deterioration in his condition was not promptly recognised and acted on by the ward staff responsible for his care.

81. For us, as Richard's family, the thought of Richard dying alone, heavily sedated, in a seclusion room, is agonising. We hope that the Inquiry will provide us with more clarity as to what happened to Richard in the lead up to his death.

Individual circumstances and characteristics

82. When Richard was around 6 months old, he contracted whooping cough; he was quite ill and subsequently suffered with bronchial asthma and breathing problems which he suffered with for the rest of his life. As a child, he had his adenoids removed to help his breathing but he often had a blocked nose. He snored badly as a result of sleep apnoea. He needed to change sleeping position frequently, usually sitting up in order to breath again; he would find himself gasping for air. I think he was also diagnosed with bronchitis. He had an inhaler.

83. Richard had previously been admitted to the Peter Bruff Ward and staff were familiar with him. For example, in their statement dated 8 August 2002, Staff Nurse **[I/S]** states: *'I was familiar with Mr Elliott's inpatient care, and I had been involved on a number of previous admissions to the unit'.* Similarly Charge Nurse **[I/S]** states: *'Like many staff on Peter Bruff I had nursed Mr Elliott on a number of previous admissions'.* On previous admissions, other patients had complained about Richard's snoring and his disturbed sleeping habits. He was given his own room as a result. The nursing staff were or should have been therefore aware of his sleep apnoea.

84. In my view, Richard's sleep apnoea was not properly addressed. I consider that he should have been referred to a sleep specialist while under NEPT's care during the pre-2002 admissions.

85. I do not consider that Richard's individual circumstances were properly taken into account during his index admission in 2002. Having entered the hospital calmly and without restraint, Richard was sedated and secluded. He was vulnerable. As above, there are concerns regarding clinical monitoring. It appears that the nursing staff observed Richard's stertorous breathing and apnoea, but there is no indication that he was physically assessed to ensure his breathing was unimpeded. According to a statement provided by Staff Nurse **[I/S]**, it was not until Dr **[I/S]** arrived on the scene, whilst cardiac compressions were already underway, that it was observed that *'Richard's nose was blocked with mucus'* and Dr **[I/S]** *'asked for suction'.*

86. In my view, Richard's vital signs should have been regularly monitored and, given his breathing issues and the fact that he was sedated, staff should have been continuously

observing him throughout the night. Had his breathing issues been properly recognised and monitored, Richard's condition may not have deteriorated to the point of becoming fatal.

Safety

Self-harm

87. To my knowledge Richard never harmed himself in any way whilst on a ward or within the community.

Restraint

88. I am aware that, on several occasions during previous admissions, Richard was restrained and forced to have injected medication. On one occasion, the restraint left Richard struggling to breathe and he lost consciousness. Following this experience, Richard feared for his life at the thought of being re-admitted to hospital. It is my recollection that Richard informed me that these events occurred during the relevant period. I remember that the events were still recent history at the time of his final admission.

89. Richard made me aware of these incidents of restraint when he was on leave from hospital or once he was discharged. I am unaware as to whether any concerns or complaints were informally or formally raised regarding this treatment. On reflection I should have raised these concerns myself; however, at the time I did not know who to contact to make a complaint, and I thought that Richard would action this himself with the assistance of an organisation like Mind.

The circumstances surrounding Richard's death

Restrictive practices

90. With reference to Richard's admission to hospital on 23 May 2002, there is concern regarding the potential use and extent of manual restraint by staff to administer him medication; the limited available evidence from the inquest appears inconsistent in this respect. Some of the witness evidence indicates he was restrained by ward staff whilst administered with the intramuscular medication, despite his apparent lack of resistance. The post-mortem examination dated 27 May 2002 also notes that Richard's body had *'an area of recent bruising 6cm in maximum diameter [...] on the inner aspect of the left upper arm'*. We were also informed by Richard's girlfriend at the time, **[I/S]** that she was told by staff on the ward that Richard was wearing a strait jacket at the time of his death. However, without having seen any of the underlying medical records or full witness evidence, I do not know whether this is accurate.

91. As I have already set out above, I have real concerns over the use of overnight seclusion on Richard when he was clearly in such a vulnerable state on admission. The arrangements for prescribing and administering rapid tranquilisation is also highly concerning, given that it appears Richard was administered three different forms of

intramuscular medication very early into his admission, notwithstanding the absence of any indications that he was aggressive or violent on arrival. There does not appear to have been proper clinical scrutiny of this decision, including whether such a significant range of intramuscular medication was proportionate and truly a matter of last resort. These circumstances surrounding Richard's death are particularly distressing given Richard's own views on the subject matter; making reference to Willow House (the secure unit at Severalls Hospital) in a letter entitled "The Barbarism of Secure Units", Richard stated that "*chemical coshes are used as weapons in the control of behaviour, as well as solitary confinement where "sensory deprivation" ensues for 24 hours a day under lock and key [...] Someone has to take responsibility now to ensure that the debilitated patient's suffering is ended, forever. [...] Would you wish this kind of service for yourself or your family*".

92. In the context of restrictive interventions, I note the written evidence already provided to the Inquiry by Dr Karale, EPUT's current Executive Medical Director, on the relevant principles and procedures governing the use of seclusion, including the need to use seclusion as a matter of last resort, and only where it is immediately necessary to contain a patient's behaviour which presents a sufficient risk of harm to others. Dr Karale also observed that, whilst all patients who are secluded must be subject to constant observations, any patient who receives rapid tranquilisation whilst secluded must have staff present all the time to undergo regular physical health monitoring, until the effects of sedation have worn off entirely.[1] I am very concerned that, in addition to the potential misuse of seclusion, Richard was not administered the intramuscular medications in a safe and compliant manner, including with robust arrangements for clinical monitoring in order to identify any adverse impact these medications, either individually or in combination, may have had on him.

Clinical monitoring

93. My other concerns regarding Richard's safety on 23 May 2002 relate to the adequacy of clinical monitoring (addressed above). It remains unclear on the current evidence whether and at what point seclusion was terminated for Richard, and what level of therapeutic observations he was subject to overnight. The frequency of the monitoring of his vitals, especially after it became clear that he was breathing abnormally, in the early hours of the morning, is also of great concern. Our concerns as a family have been amplified by the fact that my parents were subsequently told by ward staff, following Richard's death, that the staff nurse responsible for monitoring Richard in the hours prior to his death left her post. As I have already explained above, it appears that no witness statement was obtained from this staff member for the purposes of the inquest, so we remain in the dark about what actually happened.

Preservation of dignity

94. Richard was vulnerable, and I am concerned that staff on the night of 23-24 May 2002 may have failed to take adequate steps to preserve his dignity. According to Staff

[1] 2nd witness statement of Dr Milind Karale, page 61 of 127, paragraphs 236 to 237.

Nurse [I/S]'s statement, at 10.25pm Richard *'had been incontinent of urine and [...] faeces [...] Richard allowed staff to remove his soiled clothes [...] [which] were placed in washing machines [...] and a T-shirt was found from unclaimed property and he was wrapped in a blanket to preserve his dignity'*. Further instance(s) of incontinence are recorded in the witness evidence between 12.30am and 3.30am on 24 May 2002, and Staff Nurse [I/S] reports that Richard was *'washed and changed'*. Staff Nurse [I/S]'s evidence continued that *'The Healthcall Dr [I/S] [...] asked us to move Richard onto the floor from the mattress, which was accomplished using the sheet'*. I am concerned that may have been the blanket that had been preserving his dignity, in which case he would have completely naked at the point of the emergency response. Even if this 'sheet' was separate to the 'blanket', I am concerned that Richard's dignity may not have been properly preserved as the staff moved him across the room and treated him. It is distressing to think that Richard may have died naked or in a state of intense physical vulnerability.

Leave

95. I was not involved with the management of Richard's leave from hospital. The only period of leave I can recall during the relevant period is when Richard was given leave to attend my daughter's wedding in August 2000, and I remember that he seemed well.

96. Richard's medical records from this period confirm that he was granted leave from the wards, of varying lengths (some up to a weekend, some a week) in the lead up to his discharges as set out below:

    a. **Admission from 25 July 2000 to 17 August 2000**

    'Community [...] 09/08/2000 [...] [I/S] [...] seen in review at PBU. [...] Due to attend family wedding this weekend, granted leave over weekend to return to ward on Monday. Plan to lift section next week and plan discharge'.

    'Community [...] 16/08/2000 [...] Planned visit by [I/S] [Support Worker] and myself [Duty Officer [I/S]] as Richard is on long leave at home following a successful weekend leave at his mother's. On the way to his home, I saw him standing at the bus stop, he was going to the Wits end group. We had been unable to make him aware of our intended visit as he has lost his mobile. He appeared well if a little sedated. He asked for a lift to town and I assessed it safe to do so. He was amicable and entirely appropriate'.

    b. **Admission from 6 September 2000 to 20 September 2000**

    'Community [...] 19/09/2000 [...] [I/S] [Care Coordinator] [...] Called to home address to follow up whilst on leave from PBU. No access visit. Left note with appt for tomorrow'.

'Community [...] 20/09/2000 [...] [I/S] [Care Coordinator] [...] seen at home with [I/S]. Richard presents as well, no evidence of psychotic thought or inappropriate behaviour, due to return to ward this pm for ward review. Getting involved in local activities again, inc. Monday group, starting a local computer course'.

c. **Admission from 8 August 2001 to 26 September 2001**

'12/09/2001 [...] [I/S] [Care Coordinator] [...] Richard has been given 1 weeks leave from today. The CPA/117 meeting is now due for 2 weeks hence, where we shall discuss the possibility of Supervised Discharge to give Richard some boundaries when he is discharged from Peter Bruff care'.

Discharge and continuity of care and treatment in the community

97. In a document entitled "The Orb Syndrome", Richard set out his view regarding discharge planning and continued care in the community, saying that "*Whilst on the unit, a carefully thought out plan of therapy should be established in order that the subject be gainfully employed doing therapy or paid work upon discharge once a return to orderly routine has been established [...] After discharge social workers should maintain contact with the service user*".

98. I have no direct knowledge regarding Richard's discharge from inpatient care and any treatment he received in the community thereafter during the relevant period. From review of the available community mental health records, it appears that Richard was discharged to the care of the Community Mental Health Team following his inpatient admissions in the relevant period. It appears he had a Care Co-ordinator appointed throughout this period, and, in 2000-2001 regularly attended sessions at the Martello Health Centre. I can provide further detail on his intervening treatment in the community, if so required by the Inquiry.

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

99. As mentioned above, Richard told our family about the restraint used to inject him with medication during a previous period of inpatient admission, but I am unsure as to whether any complaints were subsequently made.

100. Richard's records indicate that he complained on 20 September 2000 regarding his care coordinator's approach to his care in the lead up to his admission in August 2000; this came after community mental health staff attended the Wit's end group to assess Richard after concerns were raised over his presentation. Richard reported feeling *'pressured'* and *'stigmatized'* by this experience and feared that *'he may become known by police as a "nutter"*. It is noted that Richard wanted *'to formally request that staff from CMHT do not go to wit's end group uninvited'* and he also requested a change in care coordinator. In response, his care coordinator agreed the following with Richard:

'Ongoing plan – wanting to be seen by me four weekly which I will respect. Will attend Monday group weekly where he will be seen by [I/S] *. Made him aware that I am happy to keep to arrangement unless I hear concerns from* [I/S] *or other areas that he may be not attending or becoming unwell. Accepted this'.*

Richard's care coordinator was replaced on 8 February 2001. It is noted in the records on 11 June 2001 that *'cpn to continue with support worker to visit at home as required in respect to Richards wishes'.*

101. Richard's records also show that he frequently raised concerns with various clinical professionals involved in his care regarding the effects of his medication.

After Richard's Death

102. I found out about Richard's death from my parents. I understand that, as next of kin, my parents received a phone call informing them of Richard's death on 24 May 2002. They then relayed the news to myself and my siblings. I was so shocked.

103. My mother told me that they were visited by staff from the Peter Bruff ward at some time between 24 and 25 May 2002. I understand that at least two members of staff were present during this visit. My mother informed me that, during this visit, staff apologised for Richard's death in their care. One of the staff members present, a female nurse, reportedly broke down and said that she had been observing Richard and that she had left her post and wasn't present when Richard fell unresponsive.

104. I was not involved in any of the investigation processes that took place after Richard's death; my parents handled matters. I understand from my mother that she met with the GP who provided her with the temporary death certificate and she was told that an autopsy was to take place.

105. Following Richard's death, I do not recall being offered any form of support from the Trust. I understand that my parents had a couple of phone calls with a doctor, but they never told me if any support was offered to them. I do not know if any other family or friends were offered support.

106. My mother told me that she received an anonymous phone call from a male after Richard's death who appeared to be familiar with the circumstances of Richard's death and his clinical history (she speculated that it might have been a social worker who knew my brother). The individual told my parents that Richard should not have died, and he advised them to make a formal complaint to prompt an investigation. Given that staff had visited my parents and verbally admitted that they failed to keep an eye on Richard whilst he was in distress, they did not proceed to make a complaint. They assumed that the hospital would take responsibility for what happened, through the inquest process, though this sadly did not turn out to be the case.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

107. I am not aware of any investigations being undertaken by or arranged by the Trust or any other relevant mental health provider or regulator. If any took place, our family was not informed and no copy of any such report was subsequently provided to us.

Other investigations or legal proceedings

108. My understanding is-that, prior to the inquest that took place on 15 November 2002 the only information that my parents were provided with was that an autopsy was undertaken and that there would be an inquest.

109. To my knowledge, my parents were not asked to prepare any statement in advance of the inquest, and they had no legal representation. To my knowledge they were also not advised about what the inquest would entail, nor of their right to make representations in respect of the issues that the Coroner should look at or the evidence she should obtain.

110. I had no involvement with the inquest proceedings. I cannot remember when I was made aware of the inquest, but I did know about it in advance of the proceedings. I was unable to attend as I was working.

111. My brother, Adrian Elliott, attended the inquest alongside my parents; they had not prepared anything to say on Richard's behalf at the inquest as, following their discussions with staff from Peter Bruff Ward, they had assumed that the Trust would simply admit accountability.

112. My parents told me that, at the inquest, they were blindsided by the Trust's defensiveness and attacks on Richard's character. I understand that descriptions of Richard in the witness evidence focused on his size, strength, and violent behaviour and that these factors were given as an apparent justification for his rapid sedation. The proceedings came as a total shock to my parents given the sympathetic and apologetic communications with Trust staff during previous contacts following Richard's death. My parents felt traumatised by the one-sided account that they heard at the inquest.

113. The inquest was heard by a Coroner alone, HM Caroline Beasley-Murray, at Essex Coroner's Court. The Coroner concluded summarily that Richard died by natural causes. No issues in respect of his care or treatment were identified or found to have contributed to Richard's death.

114. In preparing this statement, I have consulted with my brother, Adrian, about what he can recall about the inquest process. His recollection is that the inquest took place over the course of only one day. Adrian does not recall there being a jury; he just remembers there being a Coroner who pronounced the inquest findings. Adrian advised me that written statements were read out, and there were also several

witnesses who provided oral evidence. In terms of legal advice and advice regarding the process of the inquest, Adrian stated:

'When you are asked to attend an inquest, you have no idea in those days what to expect. You have no advocate to advise you, you have no idea if you can question witnesses or anything. Mum and dad where totally in awe of what was going (like rabbits in headlights). So you just sit and listen till the end and they ask you if there's anything you'd like to say. I bet there were things mum and dad would have liked to say and probably did to others after the event'.

115. Adrian informed me that, following the inquest, he formally notified the Coroners' Court of his disagreement with the findings regarding cause of death, as he considered that medication, rather than Richard's congenital heart abnormality, would have been the main contributing factor in Richard's death. Adrian did not hear back having registered his disagreement. I consider that expert medical evidence should have been sought from an appropriate expert with cardiac or cardiac pathology expertise regarding Richard's cause of death.

116. In the absence of a full and fair inquest process, in which we as a family were properly informed and able to meaningfully participate, we have many unanswered questions about what happened to Richard, whilst in the care of NEPT, in the hours preceding his death. In other words, we still do not have closure.

Your Views

117. As mentioned above, Richard raised the following concerns regarding his inpatient treatment during previous periods of inpatient admission:

    a. Over-medication and side effects of medication;
    b. The use of restraint during inpatient admissions; and
    c. Lack of liberty and contact with friends and family.

118. As discussed, I consider that mental health professionals should have offered to reduce Richard's medication until he was functioning on a low maintenance dose.

119. I also consider that Richard should have been offered talking therapy on a one-to-one basis with a trained mental health professional. Richard's records indicate that he was accessing support groups during the relevant period, but there is no indication that one-to-one counselling or therapy was ever offered to him or provided. Talking therapy may have helped him to learn coping techniques to help him to better manage his illness. Instead, Richard found himself in a cycle of relapsing, being admitted to hospital, and frequently being over-medicated.

120. Further, Richard's family, girlfriend, and other loved ones should have been given greater input into his care and treatment, especially during his inpatient admissions, throughout the relevant period.

121. Although the treatment that Richard received preceding his admission on 23 May 2002 had a significant adverse impact on his life, and I do not want to overlook this, it was the circumstances of his death and the subsequent inquest which left our family traumatised. My mother never recovered from losing her son; her last words to Richard involved persuading him to comply with the admission to Peter Bruff Ward, and she never had the chance to ask his forgiveness in relation to the events that followed.

122. In respect of Richard's final inpatient admission to Peter Bruff Ward on 23 May 2002, I have already set out the concerns we hold as a family, which are heightened by the lack of information we have as to what happened in the final hours before his death. In particular, I am concerned by the use and extent of restrictive practices against Richard, including the use of force, seclusion, and possible over-sedation. The nature and adequacy of the clinical monitoring he was subject to, both physical and therapeutic, is also of central concern. It is my hope that the Inquiry will investigate how these matters affected Richard directly during his admission, as well as other patients more generally who were admitted to the Peter Bruff Ward during this period.

123. Please see the below list of documents that I possess in relation to Richard's care under the Essex Trusts, in case any are considered of relevance to this Inquiry:

List of Documentation in Catherine Peck's Possession		
Item	**Date**	**Document Title**
Coroner's Bundle		
1	15 November 2002	Inquest Findings
2	Undated	Inquest Introduction
3	15 November 2002	Coroner's Certificate After Inquest
4	Undated	Witness Lists
5	24 May 2002	Report of Death to H.M. Coroner
6	27 May 2002	Coroner's Post Mortem Examination of Dr [I/S] [I/S]
7	1 July 2002	Supplementary Report to Coroner's Post Mortem of Dr [I/S]
8	26 June 2002	Toxicology Report of Dr [I/S]
9	Undated	Statement of PC [I/S]
10	27 May 2002	Statement of PC [I/S]
11	9 October 2002	Statement of [I/S]
12	9 August 2002	Statement of Charge Nurse / Ward Manager [I/S]
13	8 August 2002	Statement of Staff Nurse [I/S]
14	Undated	Statement of Staff Nurse [I/S]
15	Undated	Statement of Staff Nurse [I/S]

16	Undated	Statement of Dr [I/S] Consultant Psychiatrist
17	24 May 2002	Statement of Person (Charge Nurse [I/S]) Identifying Deceased
18	22 May 2025	Email correspondence from Essex Coroner's Service confirming provision of full file.
Medical Records		
19	1989 to 2002	Essex Partnership University NHS Foundation Trust ("EPUT") Records.
20	25 April 2025	Email correspondence from EPUT confirming provision of all mental health records held by EPUT and confirming that the Trust is not in possession of records for other services.
21	25 April 2025	Email correspondence from East Suffolk and North Essex NHS Foundation Trust confirming destruction of records circa 8 to 10 years.
21	1 May 2025	Letter from Primary Care Support England confirming destruction of records 8 to 10 years after the death of the patient.
23	12 April 2025	Email correspondence from Mayflower Medical Centre (Richard Elliott's last known GP) confirming no record of patient.
Letters, Notes, Articles, and Poems Prepared by Richard Elliott		
24	1985 to 1996	Timeline of Events
25	Undated	"Starting My Life All Over Again": Notes Regarding an Inpatient Admission to Hospital.
26	Summer 1994	Article in Linking Hands: A Voice for Mental Health Service Users.
27	Undated	"Why do Mental Health Problems Change over the Years"
28	1 May 1994	Poem entitled "The Medication History Man"
29	3 May 1994	Letter entitled "What is Wrong with the Medical Model"
30	6 May 1994	Letter entitled "Hybrid Hormone Secretion"
31	28 May 1994	Letter entitled "The System of Compulsory Treatment Under The Mental Health Act is Abused"
32	31 May 1994	Letter entitled "What is the Answer to Mental Health Problems"
33	2 June 1994	Letter entitled "Victims of Society's Stigmatism"
34	6 June 1994	Poem entitled "Sharing, Linking, and Loving"
35	7 June 1994	Letter entitled "Society's Menial Tasks"
36	12 June 1994	Letter titled "The Carers of the Mentally Ill Receive No Support"
37	19 June 1994	Letter entitled "Social or Antisocial Work"
38	29 June 1994	Letter entitled "Medication for the Mentally Ill and the Need for Case Registers"
39	30 June 1994	Letter entitled "Mental Illness Can Happen To Anyone"

40	17 July 1994	Letter entitled "Help Wanted, They're Killing Me and My Friends"
41	26 September 1994	Poem entitled "Talking Treatments"
42	31 August 2000	Letter Regarding Wit's End Support Group
43	1993	The Orb Syndome '93
44	4 August 1994	Letter to [I/S], Policy Director, N. E Essex Mental Health Services Regarding Inpatient Psychotherapy Counselling and Homeopathic Services.
45	Undated	Letter entitled "The Barbarism of Secure Units"
46	8 September 1994	Letter entitled "The Pleasure and Pain of Psychiatric Medicines"
47	29 September 1994	Letter entitled "Mood Transference in Group Settings"
48	17 April 1994	Letter entitled "Why do Mental Health Service Users Suffer the Debilitating Effects of Medication?"
49	18 May 1994	Letter to the Vice-Chairman of CHUMS (Colchester Health Users of Mental Services) Regarding Failures of Services.
50	28 May 1994	Letter entitled "The System of Compulsory Treatment Under The Mental Health Act is Abused"

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

    a. Any further documentation in the Trust's possession regarding the circumstances of Richard's assessment and subsequent inpatient admission on 23-24 May 2002, including all/any inpatient records;
    b. Documentation relating to any internal investigation undertaken by the Trust regarding the circumstances of Richard's death; and
    c. Full copy of the inquest disclosure obtained by the Coroner's Court, including all relevant witness evidence.

Recommendations for change

125. I would like the Chair to consider closely the duty of candour, and the Essex Trusts' compliance with this duty in post-death investigations. For example, in Richard's inquest, it appears that evidence provided by certain ward staff may have been exaggerated, including the degree of risk to others and resistance that Richard posed. Statements of truth have not been signed by the witnesses when providing their written evidence. There was also inconsistent evidence regarding a search of Richard whilst on the ward, and as to whether he had a knife on his person, as well as whether he was restrained and appropriately monitored. Without the benefit of legal representation at the inquest, we as a family were unable to test this evidence and explore the apparent inconsistencies in order to understand what in fact happened. We do not believe that the Coroner did. This was despite the fact that the Human Rights Act 1998 had come into force by then, although the case of *Middleton* had not

yet been decided. I would ask the Chair to look at whether reforms may be needed in this area in order to ensure that Trusts engage with bereaved families in an open and transparent way following the death of their loved one.

126. I would also urge the Chair to make recommendations at the conclusion of this Inquiry which would ensure proactive and timely family involvement in a patient's care. Families should be consulted from the beginning of the treatment process, with an opportunity to be directly involved in, or consulted about, important mental health assessments, rather than being notified of the outcome afterwards. Families should be involved throughout a patient's care pathway, where the patient supports this.

127. In our view a patient's situation should not be allowed to become so critical to the extent that the only option for treatment is inpatient admission. A range of potential treatment and medication options should be explored in the community, at an early stage, in order to prevent such situations. Richard's treatment became a "revolving door"; discharge on strong medication, becoming unwell, and being re-admitted. A holistic approach should be taken to recognise a patient's individual needs and circumstances and to treat them appropriately. There is not a 'one-size-fits-all' solution for provision of mental health care as each patient's circumstances differ.

128. Collaborative involvement of a patient's family members and loved ones would help ensure that a patient receives an appropriate, individualised care plan. I urge the Chair to make recommendations which will ensure ongoing and effective care for mental health patients.

129. I also urge the Chair to make recommendations which will ensure that bereaved families are provided with proper support, guidance, and legal advice in respect of navigating the inquest process, without which an already grieving family can face significant additional distress and trauma.

Signed: [I/S]

Dated: 5 June 2025