Witness Name: Emma Cracknell

Statement No: 1

Dated: 11 June 2025

# THE LAMPARD INQUIRY

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## Witness Statement of Emma Cracknell

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I, Emma Cracknell, will say as follows.

### Preliminaries

1. My name is Emma Cracknell.

2. I am the daughter of Susan Spring. My mother was born on 13 July 1957 and died at home on 1 February 2012.

3. In October 2024, I gave a commemorative statement to the Inquiry about my mother's life and the impact of her death on our family. I subsequently met with members of the Inquiry team, on 1 May 2025, to talk about the mental health difficulties that my mother faced, and the care and treatment that she received from Essex Partnership University NHS Foundation Trust ('EPUT'). I now make this statement to the Inquiry to address the matters that I raised during that meeting.

### Diagnosis and Timeline

### The First Attempt to Take Her Life

4. I first became aware that my mum had tried to take her own life when I received a phone call from my mum's partner [I/S] on 11 January 2012, telling me to go to Broomfield Hospital. The call was vague, he didn't tell me properly what had happened, he just said come to the hospital your mum has taken an overdose.

5. She had a bad back, and so I thought she had just over done it on the painkillers. I didn't realise how urgent it was. I got there and she was in a coma. I saw her arms bandaged and asked what happened.

6. Her partner said that he had called an ambulance because she had slit both wrists and laid in a bath. She was in her work clothes. She had taken a large number of tablets. I learnt about this when I got to the hospital.

7. Before this incident I was not aware that my mum had any problems with her mental health. I had just got engaged. All of our conversations since Christmas had been about our engagement. It was the first Christmas in a new house with my in-laws-to-be. It was going to be a good Christmas, but her partner couldn't make it [I/S] [I/S], so mum only came for a couple of hours. Christmas didn't go to plan but that is no reason to end your life. We were talking about going to wedding fairs together.

8. We were worried about finances of the wedding and how to manage it, but it was just chit chat. Mum was concerned, and we had a spa day booked so that the two of us could discuss it. All conversations that we had leading up to that incident were forward-looking conversations and she had so much to look forward to.

9. The phone call from Mum's partner was so unexpected.

10. When mum came round after that incident, she didn't even have an explanation as to what happened, just that she had blacked out. She said it would never happen again and that she was sorry. That person wasn't my mum, she was a quivery wreck. I think she felt so bad she had let her partner down and us down and just felt so bad.

11. I don't know how long she had been in A&E before we got there.

12. I believe that she went to A&E by ambulance because she was in coma. She was resuscitated in the ambulance. She was in a big private room. They gave her the drug that wakes you up. They were worried about what she'd taken. Me and my husband drove back to Braintree and got all the packets of medication. She was awake by the time we got back to Broomfield Hospital. She had just taken them all.

13. Her partner had found her in the bath. That's why I think it was-premeditated. She had gone and got her medication, so she had a large quantity. I think it was more premeditated than she thought. She said she was driving to work, and she had stopped and thought I can't do this and turned around and got the knife and run the bath. She knew her partner was at golf.

**The Day She Died**

14. On the day that mum died (on 1 February 2012), mum was concerned she had so much time off work because of her hysterectomy and complex background of back pain. She had only just got back into work, I can't remember if it was her first day back.

15. She felt pressure about going back to work. The letter she received was on the arm of the chair she had been sitting on which was from the Essex police, that said she was going to be on half pay because of all her leave. The letter was dated 28 January 2012 but she received it on the 31 January 2012.

16. Essex police later said it was a standard letter, one that is just sent out to everyone, but it didn't say it was going to be a conversation and it would have been worked through. The letter didn't reflect that it was going to be like that, and that it would be a conversation.

17. Given the frame of mind she was in, I ask why are they even sending these letters, when this lady had tried to take her life? She shouldn't have been receiving this correspondence. She couldn't make decision about what she wanted for dinner let alone read a letter like that and understand it properly.

**Assessment**

18. After mum died, I did find out that she had been on anti-depressant medication before, but she had never told me.

19. The most frustrating thing was that the suicide attempt on 11 January 2012 was not taken seriously. I don't know why she wasn't sectioned. I know they asked her with her partner present whether she wanted to be sectioned. It's like asking a child. There has to be a point where the medical professionals take ownership of the situation to say 'this is severe what you have done, and we need to look after you even if just for a week.' If she had been admitted she could have seen a psychiatrist, got on the right medication and then put in a support plan for when she came out.

20. Mum was admitted to Broomfield A&E on 12 January 2012 and was not discharged until 17 January 2012. During those 5 days, she only stayed in hospital because she required a review by a plastic surgeon for the injuries to her wrists, and there was a wait for this. This review kept being pushed back, with her required to take nothing by mouth for the time she was waiting.

21. During this time only one person went to see her, she asked for her partner to be present. She should have been seen alone. [I/S] [I/S] [I/S] When Mum was in A&E no one asked about that. No one thought to ask about the background or whether Mum should have been seen alone. They did not know the relationship and they did not ask.

22. My mum did mention to me 'I need to move out and be on my own' when we were collecting her prescription when she was discharged, this was first time I had seen this from her. I did see post it notes from him when I was going through her stuff saying 'I'm sorry'. Her partner was a grumpy guy and moody and could be a bit controlling. My

mum didn't want to go back to work but wanted to stick it out because of the good pension received from a long service in the police. Her partner had retired.

23. My mum had a good friend at work and her partner was saying she was a lesbian having an affair, but my mum's friend had breast cancer, and she was being there for her. It got to the point where mum would have to ring her friend from the car. To me it was a weird thing after being together for so long, he wanted her to stop work and be at home with him all the time. He was bored and retired and wanted her home and I think he was trying to get her to quit work.

24. She wanted to leave this world when she attempted to take her life on 11 January 2012, why would they return her to where she was when she was feeling like this? Her home or personal life situation wasn't investigated before she was discharged, they didn't ask her at all. Instead of asking the woman to choose, they should say protocol is you need to speak in private, and it shouldn't be an option.

25. I wasn't told there was a question of him leaving so that she could speak privately, but the report that I have seen says that. I don't think there was any understanding of him not being there or any thought about whether there might be problems between them that might mean that she should have been spoken to alone.

26. What more did she need to do? What are the criteria and what level? How could she make any choices? The last choice she made was a horrendous one and now they are asking her to make another choice, it didn't make sense.

27. They say the offer of admission was given but it was not recorded, it was very general. She should have been admitted. They needed to say 'we are taking this very seriously and you need to be admitted.'

28. I remember going in to see her, I think I went every day. I hope it was every day, but I might have taken some turns with her partner I remember washing her and laughing saying this is what I will be doing when you're old when looking after you.

29. After the attempt and being in the general ward, she didn't seem like our mum. She was quite rude; she was like a different person. I remember eating a packet of crisps and she was saying 'she's going to put on weight'. It was like someone after anaesthetic where they say just the first thing that comes into their head. I remember thinking they're going to think badly of her as she doesn't normally speak like this.

30. When she got home, she was just on a different planet.

31. On the general ward she just wasn't herself. You're talking to a very sick person at this point and to make decisions without speaking to anyone of sound mind, like speaking to us and asking whether we think she should have been admitted? We might have said no, but they didn't speak to us. She was an ill person after that point.

32. In those days in general hospital, she was on the waiting list for review by a plastic surgeon so the board said she was not allowed any food as they didn't know when she would need to be taken down to theatre for surgery. I don't think they were starving her, but I remember registering she's still not able to eat each time I would go in and see it written on the board.

**Care management and plans**

33. I could see there was no communication with anybody. Not even just the slightest support plan before she was discharged on 17 January 2012. She had me, her sister, step-daughters, best friends, aunts and uncles. There was a support network that could have been drawn on. They could have recommended a rota or support plan. In line with what my mum was happy with as well. There was no conversation with anyone. They were just strangers off the street, yes medical, but we should have moved well passed that when it came to the point of her returning home.

34. There should have been some meeting or guidance about what she needed and how to support her and how to organise ourselves to do so and what to look out for. They had none of these conversations. There might have been one conversation like this between the hospital and her partner but not as far as we know. We were walking around like zombies. We could have done with someone picking us up and saying this is the general framework of support for families and we can tailor it. Or this is what some find helpful, this is what some find supportive.

**Treatment**

35. Mum was on medication after her attempt. She had heavy anti-depressants and hadn't been having food.

36. No anti-depressants were prescribed in hospital when she was discharged. I went to the pharmacy with her after she was discharged. I remember thinking I cannot believe that she has to go to the pharmacy and pay for these tablets when she is so sick. What if she didn't want to? Thankfully I was there, but what if I wasn't? Why are the tablets not being handed to her when she leaves hospital?

37. I think they say it takes two weeks for anti-depressants to kick in. It hadn't been two weeks before she was discharged. She was not taking anti-depressants until after her discharge. She was not prescribed anti-depressants in hospital and only started taking medication once she had left hospital.

38. She did book a GP appointment and didn't want me to go to that. I waited in the waiting room, so I don't know what that conversation was. This was after the hospital stay.

39. She didn't want me to go in there, I assumed because she wanted to have her first open and honest conversation. It wasn't her normal doctor. I had tried to get in touch with him our old family GP from our old practice, but you know what it is like trying to get past reception at the doctors. He finally rang me on 2 February and said he was so sorry, and she should never have come home, but it was too late. If we could have had that medical professional conversation with someone who knew the family, and who she trusted, maybe that could have made a difference.

40. I don't know if anything would have made a difference, but if I felt everything that needed to be done had been done then I could accept what happened. But I can't do that.

**Individual circumstances**

41. Mum had had a hysterectomy and had a history of complications with her back.

42. She was always on some pain killers. I don't think they had any adverse impact on her, but they obviously weren't working that well.

**Discharge and continuity of care and treatment in the community**

43. There was no conversation between me and any doctor or nurse about mum being discharged. I think I found out she had been discharged from a phone call from either her or her partner saying she was home. I wasn't the one who took her home.

44. I was relieved she was discharged, because I thought that means she's ok, they've screened her and done their jobs and they think she is going to be ok and she has the right support.

45. It was only after her death that I realised she wasn't screened properly. I thought they would have a meeting arranged or speak to mum, but they didn't. It was ad hoc sessions when they felt like popping around so she couldn't do anything. She couldn't come to mine for the day, or go for a walk and be out as she just had a panic, she was waiting for their visit all the time.

46. She was given a horrific handout, it was huge but totally unreadable. Lines were missing and pages were printed wrong. There were so many pages and yet you were not able to read much of it.

47. She was given a meditation CD with no way of playing it. The CD was handed to her in a pack, with no suggestion that she listen to it in a session with someone.

48. Also, there was no checking she was in a fit state to read these things. Some of these things, like the realisation in black and white of seeing what people think you're going through, could make things worse. The way they just handed her a pack and sent her on her way was awful.

**2 weeks between discharge and death**

49. Mum was seen by Dr [I/S] on 18 January at home, but I don't think I was there.

50. This meeting is when they came up with a grid with recommendations which said things like 'reassure that change can sometimes be good'. It took no account of who she used to be, a policewoman, a professional. It was all sort of dumbed down like it was for a child. Maybe that's what she was needed at the time, but I didn't think it was appropriate. It was actions they were working to and some recommendations.

51. I didn't talk to her about what she thought about the support plan.

52. I didn't know anything about the adjustment disorder at the time, I only found out later. Mum was worried about work, but only because she was worried about going back in again.

53. I didn't speak to her partner about what had happened with Dr [I/S]

54. Before mum died I never saw a piece of paper that was her home plan. I saw it after she died. It had 3 smart targets. It wasn't discussed with any of us. Those smart targets were not appropriate.

55. I think visits were pretty much every day. It says it was every day on the Trust report.

56. There were all these excuses about the distance between clients, and that it was difficult to visit frequently, but that's not my fault. I only met with one lady who didn't even take her coat off. I don't really remember the home visits. I don't think they were ever very long, just about 10-20 minutes each time. It was never any more than us having a conversation about it at the time. You wait all day for them and then they're not there long. No piece of work or session, more a check in than a support session.

57. On the visit I was there for, the member of staff didn't remove her coat. She picked up a bottle of pills and rattled them at my mum and said 'here's your medication, you're going to be rattling with all these'. It was not appropriate. We wanted her on those, I thought please don't put her off them. She also said 'don't rely on these' or something. It was a very negative idea about taking medication and how it was being portrayed. It was not helpful as we wanted her on them.

58. Mum was just on the chair, she was just so high anxiety on everything and she was so worried. She felt that she had to take the medication but also didn't want to rely on it. Someone who is the professional is saying 'don't be on them too long', 'don't be addicted', 'you'll be rattling', which was not helpful. It affected her and she didn't want to take them after that.

59. I think at the time me and Mum would have just laughed at the embarrassment or awkwardness. I held onto it because it was just completely inappropriate.

60. She stopped taking the diazepam which affected her ability to sleep. I can't remember if it was after the comment. It would have played heavily on her mind, I am sure. No one wants to be on anti-depressants either. It was an insensitive thing to say.

61. In the kitchen, the woman just said 'this will be our last visit, we are going to be discharging her now'. I said look at that person in there, that's not my mum, you've not fixed her you can't leave her with us knowing she's not well. The response was to go back and talk to somebody about it.

62. I rang the crisis team who were looking after her the next day and said you need to come out and see her. Both her and her partner were on the phone to me besides themselves.

63. I remember it was 1 February 2012 and I had got tickets with a friend to see Lloyd Webber's 'Dorothy'. I spoke to mum and her partner on the phone, and they were both just in a mess the day before.

64. My aunt was head of HR in her department, and I thought this is perfect my aunt can talk to my mum about the concerns she has with the letter she got. I had rung the mental health team and asked them to go and do an extra visit. I spoke to the administrative assistant. Both these things never happened. They lied in the report and said they offered me a carer's assessment, but they didn't. This was never offered at any time.

65. They told me on the phone that they would go out to mum and visit. I went to London to the theatre show, her partner went to golf and they didn't visit and that's when she died.

66. On 31 January 2012 I rang the mental health crisis team and said mum and her partner were an absolute mess. The person I spoke to said someone would go out the following day. They had been in the morning when her partner was there and spoken about work.

67. I think it was 31 January when they said it was the last visit, but I can't remember. When I said to the person visiting that day you can't make this the last visit but I think that was the last visit. This is why I rang because I thought someone needs to come and see her.

68. When I got off the call on 31 January, I thought someone was going out, and I thought my aunt was going to call and both things did not happen. Why her partner went to golf that day when I was also out that day I don't know. Someone could have gone to see her, her best friend lived around the corner.

69. I don't know how she managed to take her life.

70. They showed me pictures at the inquest, but I didn't want to see those. The coroner had pictures, but I didn't want to see them.

71. I didn't see what she used and things, I don't know if it is something she would have done on her own or had an accomplice. I don't know how she even thought about it all.

72. Then again, she's a police officer, she had responded to so many of these things and seen it. She would always say I would never do this; I would just run and hide in the Bahamas.

73. But I know there is a problem when I try to put my rational brain and logic with nonlogic.

74. I am glad I saw how ill she was, if she had died the day of the coma, I never would have gotten over it as I wouldn't have known how ill she was. I don't know what switched, but it did.

75. I got a phone call from Mum's partner when I was back at the train station and he said 'I'm at yours where are you?' I didn't think too much, I just drove home. He could have come over to say he couldn't look after her anymore or to discuss a plan, I don't know. When I got home the police officer had been and told my partner that my mum had hung herself in the garage but I had missed the police her partner told me.

**After Susan's death**

76. In the immediate aftermath of mum's death, no one from any organisation contacted me.

77. I don't know about her partner He just went crazy; he was just so angry.

78. [I/S]

79. My friend got the rest of her things. He was just so angry with me. Horrible to me, just angry.

80. He didn't come to any of the complaints or meetings, that was just me and my dad.

**Quality of Investigations Undertaken or Commissioned by Healthcare Providers and other investigations.**

81. I received the report from the hospital around April/May 2012, because of all of my complaints.

82. I started making complaints on 18 February 2012, starting with a letter I wrote on 18 February 2012 to H.M Coroners Office, Essex County Council.

83. I only had one meeting with the hospital in relation to my complaints, but I had correspondence going back and forth. They were two lovely ladies from the Trust at the meeting, I can't remember who, but it was 'we'll take this and learn from it'. I don't know what I expected them to say, but I wanted them to say they've let us down. It was in between the letter and the report, so I think in March/April.

84. No support was offered to me and my family before the investigation or during it.

85. I think I just got a letter being told about the coroner's report.

86. The coroner was lovely to me, she recorded that mum died of 'not sound mind,' which makes a difference.

87. I just remember at the inquest the photos on the table, my dad interjected and asked how she died, and I asked him to stop as I didn't want to know the details.

88. The NHS complaint response was just excuses. They eventually came back with a list of recommendations. They had some bad failings which they did acknowledge, but nothing ever came of it. The recommendations are just in a letter replying to my complaint. Sadly, what I wanted them to do was give me my mum back and after I realised no one could do that, I gave up. They listed all the breaches of duties.

89. There was so much to and fro, me and my dad had lots of correspondence with the Trust. Dad felt like we had accomplished what we needed to do as they had acknowledged and come back with recommendations. This is when I went on my own to go to the solicitors myself. I wanted her back and realised all this complaining wasn't going to make a difference. Only when the Inquiry came up I realised that I did have reason to be so cross. My dad was like look what they're doing, look what they're asking for. We had no idea there were other cases, we thought it was just us.

90. It is so sad there are so many others, it is a weird feeling, to be relieved to be one of many but to be so sad so many others have been through what we've been through.

91. The Trust completed a Single Clinician Investigation report dated April/May 2012, written by **[I/S]** which contained a number of recommendations. I have set out below a summary of my response to those recommendations:

a. The report recommended that 'if, following an assessment and Home Treatment being planned; a service user remains on a medical ward; CHRT staff should ensure that the medical reason for this is understood; that medical staff are aware of the assessed risks and that a risk management plan is in place'. I agree that yes, they needed to do a risk assessment.
b. The report recommended that 'if there is a number of days delay between assessment and discharge home from a medical ward, a service user should be reviewed prior to discharge home. I agree as yes, lots of things can be changed in a day.
c. The report recommended that the risk assessment and management plan be 'completed following face to face contact. I agree that yes, you would think risk assessment should be done face-to-face
d. The report recommended that the CRHT Mid should 'review key worker allocation system' which should be based 'on geographical location and case load numbers'. I agree that yes – that was their excuse for not being able to see her regularly and the time being so sporadic
e. The report recommended that anxiety management information should be 'conscise and easy to use' and that the booklet "What is Anxiety" be used. I don't know what the booklet is but anything that's more manageable than the 20 pages that were given to her. Again, that should not be a one size fits all. I don't think they would just walk in and give her a booklet. It should be done in a practical way. It shouldn't just be an instruction manual. It should be worked through together not just a big booklet. It would be nice to be talked through. I don't know how long the sessions should have been but should be long enough to work through things together and assess her properly.
f. The report recommended that 'service users being home treated should be seen alone at least once during an episode of care'. I do also agree she should be seen alone once. I know I come from background of working in domestic abuse. It should be done for safety but also as sometimes people can't have open and honest conversations, she didn't want to say things that would hurt me or her partner. This is why I didn't want my dad to come in here today is I didn't want him to just be upset again and hear all the things that hurt me. There are two points, firstly there's a potential for coercion and control, but also the other point is about being more open if being seen alone by a professional. Mum didn't want to make me worried and said it was an out of body experience and that she blacked out. I didn't know my mum was even on ani-depressants prior, as she would protect me about the bad world. She was protective of me, she would give me the right information to look after myself but wouldn't lean on me like that as it was an appropriate mother daughter relationship.

92. I agree with all the recommendations of the Trust and added my own of having a carer assessment to be carried out and completed. They needed to see if her partner and I were in a good frame of mind to provide that care. They didn't even know if we

were mentally or physically able to look after her [I/S]
[I/S]
[I/S] They didn't know if he was working or in London. There were so many people to support her and there was no discussion.

**Other complaints, investigations or legal proceedings**

93. In the cycle of grief, you get so angry, so many people let us down. We complained to the police, the NHS, the mental health team, even our solicitors at the time.

94. I did complain to the police about the letter, it was thoughtless to send it to my mum at that time. This was when they told me that it would have been discussed, but that's not what the letter said.

95. All complaints I made were in writing to the crisis team, NHS, police and solicitors. I have copies of the complaints.

96. I got money back from the solicitor, 5%. But I don't think the claim was dealt with properly.

97. The police explained themselves and apologised. I got the number of the top police officer to talk to if I had concerns, which I didn't use. It wasn't handled the way I wanted it to be. I did have a police funeral for my mum and had the whole works, so that was lovely. I don't know if that was compensation, but I never received a bill or anything for that.

98. When instructing solicitors, they said I might get compensation for how many Christmas and birthday presents I missed out on. He said 'how much did she used to spend on you?' I said it is not for money. I wanted it to change, I wanted something to change.

99. The Trust say that they comprehensively assessed mum, but Dr [I/S], a psychologist who wrote the independent psychiatric report dated 5 December 2013 for my solicitors disagreed.

100. I was hounded by a reporter who wanted the gossip side of it from the police side. They wanted and interview for the newspaper, and I didn't want to do that.

101. My dad did instruct a private investigator after mum's death, to try and find out about the lead up to it and more about it, but that came to nothing. We were just trying to get answers of how mum went from being such a lovely lady to where she was. My husband had asked my dad and mum separately to take my hand. My mum was so proud and so excited. How did it go from that and being so excited to 11 days later being laid in a bath fully dressed. I couldn't comprehend. She was such an amazingly strong person, and I just don't understand what happened.

102. At page 11 of Dr [I/S] 's independent psychiatric report he states:
    a. There was 'considerable deficiencies in the care provided' from a 'psychiatric perspective during her stay in hospital and after discharge from hospital', care provided was physical in hospital;
    b. '[S]he did not receive an appropriate and thorough psychiatric assessment in hospital';
    c. Her 'severe form of masked depression' was not taken into account.

103. I think his assessment was very good actually. On page 12 he refers to there being no consistency in her review, outlining that aspects of this failure 'included the carer's assessment not being obtained'. I agree with the statement.

**Recommendations**

104. In my view the most serious failings in mum's mental health treatment were:
    a. Not being sectioned. Having that question so lightly thrown, I do think what is the criteria, what else did she need to do to be taken seriously? She needed a psychiatrist at the time and that assessment to be done on her own, and they should have insisted to question her on her own.
    b. We needed a care assessment for the whole family to take place, to ask who are we letting her back with, is it a safe environment, can she afford to pay the bills? She may not have had any sick pay or if she had been self-employed, they should ask would she be totally out of pocket now?
    c. Medication should be administered during hospital admission, so she wasn't getting transport, paying for it herself and having to administer it herself.
    d. Support plan/package saying this is what it will look like, we will be coming on these days within this window of time so we could have taken her out for a walk or coffee in the morning or taken her out for dinner. I rang them about this, and they said it was too difficult to give a window. Mum then worried about not being there. I came up with saying ring her when you have an idea on the day, if you give 30 minutes notice of someone being on the way we would have got back from wherever we were. That didn't happen.
    e. The Cognitive Behavioural Therapy (**CBT**) never happened. That offer was made on the Thursday and then they didn't come. I don't know why they didn't come. They didn't tell my mum why. It just didn't happen and never got started. Maybe that could have been introduced a bit earlier and could have been more helpful. It just needed to be put in place. My mum had pinned a lot of hopes on the CBT; we thought it would be really good. Mum was overwhelmed with anxiety. Families pin hope on things. I don't know if anything would have made a difference but know will never know.
    f. When they said to me in the kitchen that they were going to discharge her, it should have been a conversation with everyone involved. I panicked

and thought what am I going to do now? I don't really know how she reacted to the discharge; she was vacant. Everything for mum was just the end of the world. She was so absent and then everything was panic. I just wanted her to just get better and not worry.

g. I think the letter from the police was the straw that broke the camel's back.
h. You need to know who you're sending someone back to. [I/S] Her partner would have to go and visit his daughter so mum would be alone there, they didn't know this.
i. They needed to speak to her family to ask about care and support and make a care plan. If they had had the conversation, we would have all been on board, they could say we know this works. They could say call us if you're worried about the following things. She presented smiling through the session and they thought her mental health must be ok now, but they don't know her before so there's no measure. Why did they not ask me, I am the person who knows what she was like before? She was smiling and nodding and just going through the motions, taking the CD she couldn't play and book she couldn't read. We wanted to be involved as well because we loved and cared for her. It so easily could have had some communication and thoughtfulness. I raised this in the meeting with the Trust, I think it was first thing on my list of my letter.
j. I know how busy and underfunded and undertrained people are, but the crisis team need to be good. This is the emergency service for mental health, they should be good. We are pinning all our hopes on you to get us through this and then it is just terrible.
k. The coat thing is so simple, it just means you're not going to be here for a long time and you're making it clear. It was not needed. It is part of just setting the scene of support and caring. She should have taken her coat off.
l. There has to be consideration to when a person might be deeply unwell but presenting in a way that they're not. It should be that whoever is carrying out an assessment of mum should listen to the family to say this is the woman she was and comparing to now because they're starting from zero. People minimise all the time and to tell someone all your personal worries and everything is hard. They should talk to someone else about how they presented before and ask what's their normal.
m. Whatever mum was saying on that day, they should have had in mind the very serious injuries from 5 days ago. This is what was so shocking. Throughout the whole report it is under self-harm, that was nowhere near to self-harm. Taking a large number of tablets, running a bath, taking knives and cutting her wrists [I/S] and lying in the bath fully clothed. [I/S] [I/S] [I/S] She attempted suicide she didn't self-harm. They didn't take it seriously enough.
n. The thing that I most want to strike home is: what does it take to take the decision out of the patients' hands when they are so obviously unwell?

**Recommendations for change**

105. To follow the Trust's own protocol. I was so cross when I read that there should have been a carers assessment that neither me or her partner had been given. They said they contacted him on 27 January 2012 with no answer. This is after she had returned home after 5 days in hospital. And was visiting them daily. We should have both had individual care assessments completed. They didn't ask, nobody knew any previous history. It is there in the protocols to be completed.

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

Signed:

Emma Cracknell

[I/S]

Date: 11 June 2025