Witness Name: Emma Sorrell

Statement No: 1

Dated: 06/06/2025

THE LAMPARD INQUIRY

Witness Statement of Emma Sorrell

I, Emma Sorrell, will say as follows.

I have set out below the questions I have been asked by the Inquiry and my responses.

Diagnosis

From the information you have provided to the Inquiry, including during a call with a member of the Inquiry's Engagement Team on 11 September 2024, we understand that although your father had had his issues, he had not had any major mental health issues until 2004.

Please tell us about the development and circumstances of Frederick's mental ill-health (even if not major). Specifically:

1. When did Frederick first become unwell? In what way did any mental health difficulties first develop or become apparent?

   I had noticed that Dad was feeling rather low in mood in December 2003, although there had been several events that had occurred shortly before this time that I assumed contributed to an understandable lower mood (**[I/S]** *).*

The first time that I had any indication that Dad was possibly suffering from depression was when he visited me the weekend before my 27th birthday in March 2004. We chatted quite happily outside in the garden with our respective partners, then we walked up to the room where I was growing my seedlings so that I could show him what I was growing. It also gave us an opportunity to be alone together. He just turned around to me and said "look at that" and pointed to his head; his hair was falling out again (he had suffered from alopecia prior to my birth in 1977). [I/S] [I/S] [I/S] [I/S]*. The day that he pointed out that his hair was falling out again was the first time that he had ever cried in front of me. I believe that the alopecia triggered a spiral of negative, depressive thoughts and feelings associated with the tumultuous marriage to my Mum.*

In her witness statement for the Inquest, his partner, [I/S]*, stated that "he suffered from depression which started about the time of his divorce". This was in 1989/90. I am not aware that he had suffered from depression throughout the entire time from 1989 – 2003 and having spoken to other members of the family and close friends, it appears that I am not alone in disagreeing with* [I/S]*s statement.*

We talked frequently on the phone and he continued to visit me every weekend. He put on a brave face. He still went to work. He didn't want to, but he knew that he had to. During the ensuing weeks Dad became progressively more depressed. I was not aware of psychosis back then, but from my emails and memory, he became increasingly delusional; it was as if he was re-living the time when my Mum left back in 1989. I think that it would be useful if I provide a little background information at this stage to clarify. She had completely broken his heart, left him with two girls to take care of and the divorce was not an amicable one. Following the divorce, due to the financial settlement that Dad had to pay to Mum, he had to sell his beautiful home and downgrade. I was only 12 -13 at the time so I do not

know what his mental health was like at this time, but I can imagine that this was a very emotional and stressful time for him.

So, coming back to the present, between the end of Mar 04 and the end of May 04, he was talking about losing his business, that his partner was going to leave him and take him to the cleaners and that he did not have any money. As far as I was aware at the time, none of these things were true, although I cannot comment on the state of his relationship with his partner at this time. It was also during this 2-month period that at some point Dad stopped going to work altogether.

On the 28th May 2004 my Dad finally checked himself into The Priory in Chelmsford, but he came home the following day. By 30th May he had re-admitted himself and had his hair shaved off on 1st June. He was still in a bad way and seeing a therapist when he checked himself out of The Priory on 4th June due to financial constraints.

From 4th June to 20th July, Dad became increasingly unwell. His partner and myself, along with a couple of family / friend members took turns in spending time with him and subtly ensuring his safety. What I witnessed and experienced during this time is something that is too traumatic for me to even begin to remember, let alone talk about over 20 years later. It was horrific to watch him relentlessly pace up and down, chain-smoking while repeatedly stating that he had "run out of time". He was unrecognisable by this stage and he frequently expressed his wishes to end his own life. We removed anything that he could potentially use to cause himself harm. In response, he just stopped sleeping, eating and drinking altogether instead.

2. How did he first come into contact with mental health services?

Note: I am unclear as to whether The Priory covers your term of 'mental health services' in this instance.

I have an email in which I mention contact with the GP prior to his private referral to The Priory on 28th May 2004. He discharged himself on 29th May

but I had to take him back to The Priory on 30th May. He finally discharged himself on 4th June due to financial constraints. During one of my emails I stated that I had suggested revisiting his GP again around 10th June but his partner had insisted that he was improving despite my disagreement.

It must be noted that back then mental health was not discussed as it is today and mental health services were not as well-known at this time i.e. I was not aware that there was a crisis team or that there were support services available. We were literally on our own, blindly attempting to keep him safe in what was, an unfamiliar situation for both of us. As far as I am aware, neither The Priory nor the GP suggested that NHS outpatient care was available. We trusted the professionals and believed that this route was our only option.

I have a record of Dad visiting his consultant at The Priory on 2nd July. Around 15th July his consultant suggested halving the dosage of one of his medications so that he could function more normally.

3. When did Frederick first come into contact with mental health services?

   Answered in point 2.

4. What were the circumstances that led to that first contact with mental health services?

   As mentioned in answers to questions 1 and 2, following Dad's self-discharge from The Priory in Chelmsford on 4th June, his partner, his partners daughter, his friend and I found ourselves observing him constantly. On 2nd July I took Dad to see his consultant at The Priory but I cannot remember the details or outcome of this meeting. Dads partner called his consultant on 15th July to raise our concerns and he halved the dosage of one of his medications so that Dad could function more normally.

From 15th July – 20th July when Dad was sectioned, his partner and I were on 24 hour suicide watch. By this stage, I reported in emails to friends that Dad was only sleeping 3 hours a night and then pacing, chain-smoking and repeatedly expressing his wish to end his life. His partner and I had caught him with a sharp knife and had consequently hidden all of the knives. His partner and I had his guns removed by a policeman. I report in emails to friends during this time that we were receiving visits twice daily from social workers. ***Note: now that I am reading this, they may have been from Mental Health Services rather than social workers i.e the crisis team.***

I cannot remember much from the events that led up to me taking him to hospital. All I can remember is someone (presumably one of the social workers / ***perhaps crisis team members****) saying that he needed to go immediately to The Lakes Hospital. Sadly, I have a mental block of this day. I can only imagine that this is down to the trauma that I experienced that day and the days of exhaustion that led to that day.*

5. How did matters progress from there? Over what period?

I drove my Dad to the hospital and he was assessed there and then. It was decided following his assessment that he should be immediately sectioned under the mental health act.

Worried sick about my Dad, utterly exhausted, at my wits-end and in desperate need of professional help, I finally signed the papers to have Dad sectioned under the Mental Health Act at Colchester Hospital on 20th July 2004.

While I was signing the papers my Mum arrived at the hospital to visit **[I/S]** **[I/S]** *. Having not seen my Mum for years, I didn't think that things could get any worse – Dad had been re-living the trauma of his divorce and there was Mum, bright-eyed and smiling as if she did not have a care in the world. At that moment I had to insist that Dad was relocated to another*

hospital because I didn't want him to see her. Thankfully he was transferred to Peter Bruff in Clacton that day.

6. In your application for core participant status, you expressed the view that Frederick may not have had to be sectioned in July 2004 if he had received adequate outpatient treatment. Are you able to tell us more about what treatment your father had been receiving before his admission under section in July 2004?

   To the best of my knowledge, this information has been provided in question 2 & 4 above.

7. Was he given a diagnosis at any stage? If so:
   a. When was that diagnosis given?

      In **[I/S]** *s witness statement for the Inquest, she states that "He had an obsessive disorder". I was not aware of this diagnosis, and I do not know by whom she received this diagnosis although in her statement, it appears that this diagnosis may have been provided by a representative of The Priory prior to his admission to The Lakes / Peter Bruff.*

      I cannot remember an official diagnosis being provided but during a discussion with one of the nurses a few days following Dad's sectioning, I was informed that he was experiencing a breakdown but that the prognosis was good.

      It was not until the beginning of October 2004 that I have record of a discussion with someone from the hospital who stated that they had not seen such a severe breakdown for a long time.

      The only formal diagnosis I received was when the verdict was read out at the Inquest and I learned that "he killed himself whilst suffering from psychotic depression".

b. What was that diagnosis?

Answered above.

c. Where was Frederick diagnosed (for example, at an outpatient appointment, at Accident & Emergency, at home, or somewhere else)?

Answered above.

d. By whom?

As best that I can this is answered above.

Assessment

8. Were there any occasions on which Frederick, or others on his behalf, sought a mental health assessment in relation to a mental health admission for inpatient care and treatment and no assessment took place? If so:
    a. Who were those requests made by?
    b. When was that?
    c. To whom?
    d. What was the reason for doing so? What were the circumstances that led to the request being made?
    e. What was the response or outcome?

Not that I am aware of.

You have explained to the Inquiry that your father was admitted to the Lakes, Colchester, under section and that thereafter, in the period before he died on 4 December 2004, there followed a series of discharges, transfers and admissions to the Lakes as well as to the Peter Bruff Unit, Clacton.

9. Before 20 July 2004, had your father ever been subject to a mental health assessment in relation to mental health inpatient care and treatment?

He must have been assessed (by the 'social workers' as I refer to them) at home prior to the decision to take him to hospital. I am sorry but I cannot remember. He was assessed at The Priory during his private admission.

10. For every mental health assessment in relation to any admission for mental health inpatient care and treatment that did take place in Essex during the relevant period, please tell us what you know about each such assessment. For example:

Please note that I was not informed of every assessment that may have taken place during his time at both Peter Bruff and The Lakes despite my verbal request to be kept informed.

I can only comment on the assessments that I was aware of and provide the little information that was provided to me.

Additionally, I would like to add that this all happened over 20 years ago and I was not recording everything; I did not expect to be in this situation and at the time, I was just trying to mentally survive through the living nightmare myself.

He was assessed at The Priory but he had to pay for that. I do not have any further information regarding this assessment.

He must have been assessed by 'the social workers', or what I am more convinced of now was the crisis team over several days leading up to his sectioning.

He was assessed when he was sectioned at The Lakes Hospital. The details of which I have already provided to the best of my ability.

He must have had multiple assessments during his time as an inpatient, but I had/have no record of any of these assessments that I was invited / informed of. The only assessment that I was invited to was on 29th

November. This was following the email and letter that I sent to Dr **[I/S]** *requesting in writing that I be involved in all assessments.*

I will answer these questions in relation to the one assessment that I was invited to.

a. When did the assessment take place?
   29th November.
b. What was the reason for it/what had led to it?
   The reason for the assessment was to discuss a possible discharge and what support **[I/S]** *and I would need require.*
c. Was it a routine assessment as part of ongoing care and treatment in the community, or an emergency/crisis assessment, for example at home or in Accident & Emergency?
   It was in The Lakes Hospital.
d. By whom was the assessment carried out?
   Dr **[I/S]**
e. Were you and/or any other family members or friends present during the assessment?
   His partner and I were present.
f. What matters were covered during the assessment?
   I cannot remember exactly. The only information that I recorded was that Dr **[I/S]** *was in agreement with me that Dad had not made much progress.*
g. What information was sought or taken into account by those carrying out the assessment?
   The similarities between his previous presentation prior to the last discharge and his presentation at this assessment was discussed. Dr **[I/S]** *pointed out that Dad was presenting in exactly the same way during the current assessment as he was during the assessment prior to his previous discharge i.e. positive. Dr* **[I/S]** *vocalised her concerns regarding discharging him because the last time that Dad was discharged he had attempted to hang himself and nearly died.*
h. What was the result?

It was decided that Dad was not well enough to be discharged at that time.

He was granted leave for one hour each day with any friends or family. If there were two friends or family members in attendance he was granted leave for up to 3 hours.

i. What were the next steps following the assessment to be, as far as you are aware?
A follow-up review was scheduled for 6th December to discuss possible leave and possible discharge before Christmas.

j. Did any planned follow-up steps occur? If not:
    i. Why was that?
    He died.
    ii. Were alternative plans made? If so, please describe those.

11. Do you have any observations, comments or concerns regarding the quality, adequacy, process or outcome of any such assessment?

I can only comment in relation to the one assessment in which I was present. I cannot remember any discussions regarding current or future amendments to Dads care plan.

Note: I called this meeting a 'review'. Perhaps this is not an assessment. If this is the case, I was not involved in any assessments. The only one that I was present at was the one at home and the one when he was sectioned. I do not have anything to measure the quality of these assessments by.

Admission

12. As set out above, we understand that you father was admitted to the Lakes under section on 20 July 2004. In your application for core participant status, as well as in an email sent to the Inquiry on 11 September 2024, you also explained that:
    a. On arrival at the Lakes on 20 July 2004, Frederick was immediately transferred to the Peter Bruff Unit;
    b. He was first discharged from Peter Bruff on 18 September 2004;

c. He was re-admitted to Peter Bruff hours later following threats to take his own life;

He was re-admitted on 20th September 2004 following threats to take his own life.

d. Frederick was discharged from Peter Bruff on 17 October 2004;

e. This was a trial period as a precursor to an expected discharge;

I am not aware that he was discharged on a trial period as a precursor to an expected discharge. I was under the impression that he had been discharged.

f. On 22 October 2004, following a serious attempt to take his own life on 21 October 2004, he was admitted to Colchester General Hospital and thereafter to the Lakes;

On 22 October 2004 Dad made a serious attempt to take his own life and was taken to Colchester General Hospital for emergency medical treatment. He was due to meet with his consultant that day (not sure if that is relevant). He was admitted to The Lakes hospital on 24th October.

g. During a review on 29 November 2004, a possible discharge before Christmas was discussed;

h. On the day that he died, 4 December 2004, he had been granted 8 hours leave with his daughters.

Yes. I found out at the Inquest that a further review had taken place on 3 December 2004 and that my Dad had made a formal appeal against his sectioning. During the review, he had been granted 8 hours leave the following day. Because my sister and I were not informed of this review or its outcome, we were still under the impression that he was only granted 3 hours leave that day (4th December 2004). Had we known the increase in hours, we would have collected him first thing that morning. This is a classic example of why the hospital should have also been in communication with me;

[I/S]

[I/S]

[I/S]

[I/S] His *needed support at every critical moment when he was poorly at home, but in hospital, she spoke and acted disparagingly about the environment that he was in. I am without doubt that she was determined to convince Dad that I was 'the bad guy' keeping him in hospital and that she was supporting his discharge (proven by the secrecy of the review on 3rd December). My motivation was to keep him safe and get him better.*

[I/S]

His partner *would keep me informed of anything that benefited her i.e. times of leave, because I was the taxi more often than not and frequently his leave time was spent with me.*

Is that timeline of events correct? Were there any other discharges, admissions or transfers during the period from 20 July to 4 December 2004? If so, please tell us about those. *No. I would have been informed of any further transfers or discharges because* his partner *needed me to 'carry the load' so to speak.*

13. For <u>each</u> admission and inpatient stay at a mental health inpatient facility in Essex during the relevant period, please tell us as much as you can. For example:
    a. What were the circumstances of the admission? What had led up to Frederick being admitted?
    b. By whom was the decision to admit made?
    c. Was the admission made under section (i.e. under the Mental Health Act 1983)?
    d. When was the decision to admit Frederick made?

e. When was he actually admitted?
f. To which hospital/unit/ward was he admitted?
g. How long did Frederick stay there for?

I believe I have covered all of these items above. Please correct me if I am wrong and I will try to clarify.

14. Do you have any information or observations you wish to share about the admission process itself on any of the occasions that Frederick was admitted or about any aspect of the way in which admission was handled?

Dad's initial admission at The Lakes hospital seemed very sudden to all of us, although we understood that it was necessary. Of course, Dad did not agree with this conclusion. We were just told that he would be safe now. We were not given any information regarding care, time-lines, diagnosis etc. This is evident in the fact that we did not take an overnight bag for him at the time of his initial admission; I took his partner *home, we packed him a bag and I returned to the hospital that evening. The entire process really traumatised both Dad and I.*

His admission to The Lakes on 24 October was decided without any discussion with me. I had already voiced my concerns regarding Dad being located at the Lakes Hospital during his initial sectioning which is why he had been immediately transferred to Peter Bruff. I do not know why he was not transferred back to Peter Bruff.

15. Were there any occasions when Frederick, or others on his behalf, asked a healthcare professional (or for example, police) to admit him or to consider doing so and he was not admitted? If there were, for each occasion:
    a. Who made that request?
    b. When did that happen?
    c. What led to that request being made? What were the circumstances or factors that led to the belief that Frederick should be admitted?
    d. To whom was the request made?

e. What was the response or outcome?
f. What was the basis for that response or outcome, as far as you know?
g. Do you have any observations, comments or concerns regarding the decision not to admit Frederick?

No.

16. If there were occasions where Frederick was not admitted despite a request to do so or to consider doing so, what action (if any) was taken in terms of alternative mental health care and treatment?

N/A.

17. If there were occasions where Frederick was not admitted despite a request to do so or to consider doing so, was a further assessment arranged?
    a. If not, do you know why that was?
    b. If it was:
        i. When was that to take place?
        ii. Who was to carry out the assessment?
        iii. Did the assessment take place?
        iv. What was the outcome?

N/A.

18. We are aware from the information that you have provided to the Inquiry that Frederick was admitted under section (i.e. under the Mental Health Act 1983) on 20 July 2004, and that he was under section at the time of his death on 4 December 2004. Do you have any information or observations you wish to share about that decision or about any aspect of that process? For example, in your application for core participant status, you explained that having to be sectioned stripped your father, who was a very proud, hard-working family man, of his dignity and freedom.

As I have previously stated, I cannot remember there being that much intervention prior to Dad's admission and sectioning on 20 July 2004. Back in 2004, mental health was not openly discussed in any way, shape or form. To be sectioned was considered to be the 'ultimate shame'. The stigma is still prevalent today. It has improved though. For Dad, it was 'the ultimate shaming'.

He had worked hard for over 30 years to build himself a respectful reputation. He was a proud, independent and dignified man, so to strip him of his freedom and for him to be 'sectioned' and grouped together with 'mentally unstable' people of varying degrees and illnesses, was devastating for him. For a man of a certain age and era, if he was sectioned, he believed that there was no going back into society and facing people after something like that, even if he did get better.

I think that we all felt overwhelmed and like it had all happened very suddenly. I understood the severity of the situation but my Dad was not in the right frame of mind at that time to make such decisions. We were not aware that he was going to be sectioned until the moment that it happened. We were not at all prepared. Dad was assessed during that meeting at The Lakes hospital and they made the decision. I agreed of course because they were the professionals and I was exhausted, traumatised and desperate.

Having to watch his daughter sign the papers to have him sectioned was, I am sure, a very demoralising and distressing experience for him. He had prided himself on being a strong, stable, dependable man to all. He was used to having control of his life and being the support figure for so many family members and friends.

We were not given any idea of how long he would be hospitalised for or information regarding what care and treatment he would receive. The entire process was alien to us and we were not given any supportive information that could have enlightened us as to the process or what to expect.

Dad was a homebody; he loved his home and they rarely went out or on holiday. All of a sudden he was placed in the hospital with hardly any belongings and surrounded by strangers with, as I have mentioned above, their own issues to contend with.

From the moment that he was sectioned, he believed in his own mind that there was no way back from this. I say this because he knew that those that loved and respected him would never look at him the same way again and his reputation was in tatters.

19. Were there periods when Frederick was admitted as a mental health patient not under section, i.e. on a voluntary basis? If so, do you have any information or observations you wish to share about the decision not to admit him under section?

    The Priory as mentioned above.

Ward Environment

20. You explained to us that you were able to visit your father almost every day. Was that between 20 July and 4 December 2004?

    Yes. There were no instances where I was not allowed to visit Dad. I had a week off at some point and I reduced my visitations toward the end due to my own mental and physical health, at minimum, I was visiting 3-4 days a week. On the occasions that I could not visit, I ensured that other members of the family or friends would visit.

21. In your application for core participant status, you explained that when your father was at Peter Bruff, he built a strong bond with the nurses, who were great at interacting both with him and with you. Can you tell us more about that?

    There was one male nurse **[I/S]** *who spent a lot of time with Dad during his 24-hour and then reduced observation times. He built up a good rapport and relationship with Dad. This relationship was earned through his respectful manner and interaction with Dad.* **That nurse** *took the time to get to know Dad and always treated him like an equal who was just going through a rough patch. They would do puzzles, play games and chat like friends. Dad trusted him and he was happier when he was around.* **He** *took the time to chat to me as well which gave me an insight into how Dad was doing and reassurance that he was being observed and shown some*

compassion. **His** *' senior also knew Dad well and would take the time to explain how he was getting on and set expectations. I really appreciated this insight because I was excluded from any formal contact with representatives of the hospital regarding Dads care.*

22. By contrast, you told us that the nurses at the Lakes were hardly seen and that you cannot remember one instance of nurses contacting either you or your father. You described the Lakes as cold, careless, impersonal and to a certain extent hostile and explained that neither you nor your father felt comfortable asking staff anything. Are you able to provide any more detail about the environment there, or about what led you to form those impressions?

I cannot remember one instance when I arrived to visit my Dad, when there would be a nurse sitting or speaking to him. The staff that were visible were distant and did not appear to be approachable. They looked pretty miserable in summary. The entire environment was utterly depressing, from the lack of interaction to the overall décor – I couldn't wait to get out of there if I am honest. I felt guilty leaving Dad in such an environment.

There was such a diverse combination of patients with varying illnesses and severity. Dad was a very quiet and polite person and used to being surrounded by similar people. In there, he was subjected to shouting, screaming, violence (not to himself personally), antisocial behaviour such as continuous and extreme belching, being approached and asked inappropriate and intrusive questions. There was a man in there who was morbidly obese. I felt very sorry for him, but his legs were covered with weeping ulcers; the entire room was filled with the stench of 100 tom cats.

The staff did not seem approachable at all and appeared to be hostile to any contact.

23. In your application for core participant status, you explained that you witnessed constant deficiencies with regards to the environment and care, and that he received very little care. You also told us that you witnessed the detrimental effect on his mental health and that he told you several times that he felt like he had been left there to rot.
    a. Was this during the entire period following Frederick's admission under section on 20 July 2004?
    There was a lot more care and communication with both my Dad and I during his stay at Peter Bruff. The utter neglect occurred primarily during his 5 week stay at The Lakes hospital in Colchester; it was a very impersonal environment and the care did not appear to exist at all.
    b. Is there anything further that you want to share about how your father's mental or physical health developed or changed over each period as an inpatient, or any other changes more generally, such as in Frederick's demeanour?
    My Dads mental health did not improve during the entire 5 months; in fact, it depreciated. He had given up and checked out. He just didn't care about anything anymore and he just wanted to die.

If you have not already covered these matters in response to the questions above, giving as much detail as you can and explaining the reasons for your views wherever possible, in relation to <u>each</u> of Frederick's inpatient stays for mental health treatment within the relevant period:

24. What were your impressions of the ward environment as a whole?

    Peter Bruff – was more of a warm, calming, nurturing environment both physically and therapeutically.

    The Lakes – it felt more like a prison than a hospital and the patients appeared to be treated more like inmates than inpatients.

25. Do you think that the ward and building were a suitable environment in which to provide inpatient mental health care?

Peter Bruff – the building felt smaller, I think it may have been. It felt safe and secure but also quite homely. The social area was quite inviting with sofas, a TV, a table-tennis table, tables and chairs to sit at and a little kitchen to make refreshments.

The Lakes – there were two uninviting social areas with chairs seated around the edges of large, sparce rooms. There was a TV in the larger room from memory. There was a room with a table tennis table but not a lot else in there apart from several chairs. It just felt sparce, impersonal and inhospitable.

26. Do you think that the ward environment met Frederick's basic needs? This could cover, for example, matters such as nutrition, physical health and hygiene.

    Dads' basic needs were met in both environments, although I cannot remember Dad having any form of exercise during his 5 week stay at The Lakes. We did not go out in the garden at The Lakes either.

27. What impact do you think the ward environment had on Frederick? Tell us about your impressions of how he reacted to being on the ward, how comfortable or otherwise he was there, any concerns that he raised or that you (or others) had about Frederick while he was there.

    Peter Bruff – Dad seemed comfortable in the environment following an adjustment period of course. He obviously did not want to be in the hospital, but he seemed more content and would engage in conversation with myself, other visitors, other patients and the nurses.

    The Lakes – Dad spent a lot more time asleep in his room. There were several times when I arrived to visit him and he was alone in his room. He did not engage with anyone apart from one other patient who he befriended (he was discharged prior to Dad's passing). He did not appear to be comfortable when we were sitting in the social areas. He completely withdrew into himself.

28. Do you think that any aspect of the ward environment assisted Frederick's recovery? For example, as far as you were aware:
    a. How did he spend his time on a given day?
    Peter Bruff – Dad spent a lot of his time chatting to his nurse, doing puzzles, drinking tea, smoking and playing table tennis. He was also taken somewhere else for some physical exercise on a regular basis. He also enjoyed going out into the garden.

    The Lakes – as I have already mentioned, he spent a lot of time in his room. Whether he spent time in the social areas outside of visitation times I do not know. There were some set activities. I remember that he engaged in a cookery session and that there had been someone to visit and offer manicure and pedicures which my Dad had declined.
    b. Were activities available to him and to other inpatients (when they were well enough to take part)?
    Answered above.
    c. Were those activities engaging and meaningful?
    The two activities that I am aware of were not at all suitable, engaging or meaningful for a man of a certain age and era; Dad did not enjoy cooking and he would not have wanted to have a manicure or pedicure.
    d. Did Frederick have access to outside space? If so, how regularly?
    I have answered this above. How regularly he was allowed to go out at Peter Bruff I could not say.

29. Do you think that the privacy and dignity of inpatients were respected (either by other staff and/or by other patients)? Please explain on what basis you have reached your views on this, including examples where possible.

    I cannot comment on this. I could only observe the times that I visited.

Staffing Arrangements, Training and Support

While Frederick was an inpatient (and for <u>each</u> period as an inpatient during the relevant period):

30. Did you have any concerns regarding the number of staff on the ward at any time? If so, please provide details, for example:
    a. What were those concerns?
       There did not appear to be many staff present during his stay at The Lakes.
    b. How did the matters you were concerned about come to your attention?
       Lack of presence of staff. There would be staff scattered around in the corridors etc. I felt like once I was there that I was responsible for observing him.
    c. When was that?
       During his stay at The Lakes.
    d. Over what period?
       5 weeks (24 Oct – 4 Dec).

31. In your application for core participant status, you explained to us that you learned from witness statements prepared for the Inquest into your father's death that the ward was understaffed in December 2004. Is there anything further that you wish to share with us about that?

    I was absolutely outraged when I discovered the reasons for the multiple failings was due to a lack of staff. If this was the case and they could not provide the adequate care that my Dad and the other patients on the ward required, we should have been informed. We were in no way informed that he was not receiving the required care that he so desperately needed. Had I known, although I should not have had to, I would have paid for him to receive private care once again.

    If the hospital could not provide the care needed, why were they allowed to continue functioning at all? If it was a hospital managing physical ailments, would there not have been protocols in place to ensure that patients were cared for adequately? If someone were to die because their drip or ventilation system was not managed due to staff shortages, would there not be utter outrage? Why should mental health patients be treated with any less respect and responsibility? To whom did the responsibility lie and why was this not escalated and managed? I am still furious about this.

It wasn't just the observations that were compromised due to understaffing; he didn't receive any psychiatric care. How on earth was he supposed to improve if he didn't receive any treatment? An analogy would be me arriving at A&E with my arm hanging off and the nurses stemming the bleeding but leaving the arm hanging to rot for 5 months....

Why was he being imprisoned in an inhospitable environment that was supposed to keep him safe and help him recover when they were not helping him to recover at all and they were obviously NOT keeping him safe?! It is utterly disgraceful and unacceptable.

The culmination of the hostile environment, lack of general, therapeutic care and psychiatric treatment massively contributed toward the rapid depreciation of my Dad's mental health and resulted in his ultimate demise.

32. Did you have any concerns regarding the training, ability or conduct of any members of staff on the ward at any time? Again, please provide as much detail as possible to help the Inquiry to understand your observations. For example:
    a. What were those concerns? To whom or to what events did they relate?
    b. How did the matters you were concerned about come to your attention?
    c. When was that?
    d. Over what period?

No. I had nothing to measure this by.

Care Management and Plans

While Frederick was an inpatient (and for each period as an inpatient during the relevant period):

33. To what extent, as far as you are aware, was Frederick involved in the plans for his care, including the formulation or implementation of a care plan?

I received care plan progress notes dated 24 Oct 04 – 6 Dec 04. I am still finding if too traumatic to read this at this time.

Dr **[I/S]** *outlined that the care plan that was in place for my Dad was that he was nursed in a safe environment, received close observations and 1:1 therapy.*

34. Do you consider that the level of engagement with Frederick about decisions and plans in relation to his care and treatment was appropriate? If not:
    a. Why not?
    b. What do you think should have been done differently?

    I cannot comment because I do not know what his level of engagement was.

35. To what extent were you, or other family members or friends, involved in or informed about the plans for Frederick's care, including the formulation or implementation of a care plan?

    As far as I am aware, none.

36. Do you consider that the level of your (or other family members or friends) involvement with those plans or the level of information provided to you about the decisions and plans in relation to Frederick's care and treatment was adequate and appropriate? If not:
    a. Why not?
    b. What do you think should have been done differently?

    We were not involved. We should have been involved. We knew Dad better than any Dr or nurse ever could. Our input and feedback would have been invaluable.

37. Do you have any concerns about any aspect of the formulation or implementation of the care plan? If so, please describe those concerns.

I cannot comment because I was not aware of the formulation or implementation of any care plan.

Treatment

38. Concerning any mental health diagnosis Frederick received:
    a. What treatment, if any, was offered at the time of diagnosis?
    I was not informed of any diagnosis. It was just decided that he should be sectioned and stay in hospital to stay safe.
    The only treatment that I am aware of that he received was ECT.
    It was stated in the SUI Executive Summary that "Unfortunately Mr Peck declined psychological input and the panel are unclear as to whether a referral was made to the psychotherapy department. Mr Peck did however attend therapeutic groups on the ward but did not actively participate in the therapeutic programmes".
    b. By whom was that treatment offered? Where was it to take place?
    With regard to the ECT treatment, I do not know who offered the treatment specifically. It took place near or at Peter Bruff.
    I do not know when psychological care was offered.
    c. Did he undergo that treatment?
        i. If not, why was that?
        ii. If so, over what period did he receive that treatment?
    He received his first ECT treatment on 17 August 2004. By 4th October he had received the maximum number of ECT treatments and I noted that the hospital had said that he needed a 4 week break from these.
    d. Where was that treatment (for example, in the community, or in a *particular* unit)?
    I do not know if it was actually at Peter Bruff or another location.
    e. Were there any changes to Frederick's diagnosis over the relevant period? If so, please provide details of those changes.
    No diagnosis provided.
    f. Were there any changes to Frederick's treatment, over the relevant period? If so, please provide details of those changes.

I recorded that following his ECT treatments that he got significantly worse. When I raised concerns with a member of staff, I was informed that this was a normal reaction to the treatment.

39. Do you have any observations, comments or concerns relating to Frederick's initial or later diagnosis or treatment, or in relation to any lack of or failure to provide a diagnosis?

There was no official diagnosis as far as I am aware. It was not until the Inquest that I discovered that he had been diagnosed with a psychotic episode. This term had not been mentioned to me during any of my conversations with staff during the entire 5 months that Dad was in hospital. The only term that had been used was 'mental breakdown'.

While Frederick was an inpatient (including during any periods of leave) and for each stay as an inpatient during the relevant period:

40. Do you think that decisions about Frederick's mental health treatment were made adequately and appropriately? If not, what aspects of decisions about his treatment do you think were not appropriate or adequate and in what way?

Of course, I cannot make an accurate judgement on this question because I was not informed of any treatment and I am not educated in a mental health profession.

I was shocked to discover that he did not receive any therapeutic treatment or psychiatric care. As previously mentioned, it was reported in the SUI Executive Summary that my Dad had 'declined' psychological input. I find it difficult to believe this statement. He may have been reticent to engage due to his illness, his age and the culture of the time. This begs the question as to how early on during his admission psychiatric care was offered, how often psychiatric care was offered to him and how they attempted to engage with my Dad. I also wonder whether whomever was responsible for his psychiatric care, I presume Dr **[I/S]** *, had considered that he was not engaging because of his illness, his age and*

the culture of the time and made any adjustments to the approach made to engage with Dad.

He was discharged several times when he should not have been – he had not received any treatment and he had not improved. His observation times were reduced when they should not have been; he had not made any improvement to support such a decision. If I could see this as a layman, surely the professionals should have known?!

If he was indeed suffering from psychotic depression, I do not know at what point that this diagnosis was made and therefore I do not know when the care, treatment and medications were adjusted appropriately to treat this diagnosis.

41. What therapeutic care was available for Frederick (either one-to-one or in a group setting)? In your application for core participant status, you explained that you learned at the Inquest into your father's death that he had received no psychological care and that his psychiatrist believed that psychological care could have assisted him, had the resources been available.
    a. Is it your understanding that your father received no psychological care during the entire period following his admission on 20 July 2004? *Yes.*
    b. Is there anything more that you wish to share about that?

    I am utterly disgusted that during a 5-month period of admission, my Dad did not receive any psychological care. If a patient admitted to a physical ward with an illness, they would be assessed, diagnosed and they would receive the appropriate treatment. I recognise the complexities surrounding the diagnosis of mental illness, but this is also true of physical illnesses. In a physical health care environment, treatment and results would have been regularly assessed and adapted until a diagnosis and possible treatment plan could be agreed. My perception was that Dr **[I/S]** *did not understand why he had depreciated so rapidly under her care and she did not seem to*

know how to treat him. It is now obvious to me – he hadn't received any care! The situation and environment just exacerbated his illness.

The only therapeutic care that I am aware of that was provided during his interaction with the nurse that predominantly engaged with him during his admission at Peter Bruff. It was stated in the SUI Executive Summary Dad did "attend therapeutic groups on the ward but did not actively participate in the therapeutic programmes". This at the very least, is evidence that Dad had not given up hope of recovery. Although he may not have participated, he would have been listening and taking everything in. He was not one to draw attention to himself in such situations even when he was mentally well.

It was stated during the SUI Executive Summary that "The panel acknowledged that there is no clinical psychologist or psychotherapist based at the inpatient unit or allocated to the ward. It remains an open question whether easy access to psychological treatments on the ward would have helped Mr Peck to enter into a trustful therapeutic relationship, that must have enabled him to address his difficulties in relationships and his traumatic past experiences."

42. Do you think that the mental health treatment actually provided to Frederick was adequate and appropriate? If not, being as specific as you can, in what way (and in relation to what specific aspects of treatment) do you think that his treatment was inappropriate and/or inadequate?

No. I think that I have answered this above.

43. In your application for core participant status, you told us that your father received the maximum number of electroconvulsive therapy (ECT) treatments, despite his absolute unwillingness to do so. Are you able to share further details with the Inquiry about that? What do you consider was the effect on Frederick of those treatments?

Dad was absolutely traumatised and embarrassed following every ECT treatment. He hated them. It was one of the few things that he actually

complained about because he was usually so polite. He would wet himself every time which stripped him of what dignity that he had left. It left him bereft.

44. Do you have any other concerns about any decisions that were made about any treatment or medication that was prescribed (or not prescribed) to Frederick? If so, please give details about those, explaining the nature of your concerns and when and how they arose. These could include the type of medication prescribed, the dosage, the effects on Frederick or any other matters that you wish to tell us about.

On 15 July 2004 I had reported that his consultant at The Priory had suggested halving one of his medications. This led to a rapid decline in Dads mental health.

Following some of his hours of leave at my home, I later reported that he was unable to focus or hold a normal conversation – this was while he was on leave from Peter Bruff.

All I can say is that he became 'comfortably numb' as the song goes. He did not care that he sat in a room with a gentleman with ulcerated legs that filled the room with the stench of a 100 tom cats. He became increasingly oblivious to his surroundings. This may be down to his mental health as well though.

Because I do not know at what point that Dad was diagnosed with having experienced a 'psychotic episode' I do not know if the medication was appropriately prescribed to manage this particular mental health issue.

The care plan progress notes that I have mentioned above (24 Oct 04 – 06 Dec 04) contains a list of the medication that he was on at this time. It is barely legible and I would not know what any of these medications do or what they were for. I do not have any records of what medication that he was being prescribed prior to this time.

45. Do you have any concerns about how any medication that was prescribed to Frederick was administered and managed? If so, please explain your concerns and how and in what circumstances they arose, giving as much detail as you can. *I cannot comment.*

Individual Circumstances

46. Did Frederick have any individual conditions or circumstances that should have been taken into account while he was being treated as an inpatient (for example neurodiversity, learning difficulties or disabilities, dementia, physical health issues or addiction concerns)? If so:

    a. Please tell us about those individual circumstances.
    b. Were the staff who were assessing, treating and/or making decisions about Frederick's treatment or involved in his care aware of those circumstances or conditions?
    c. Do you think those individual circumstances were appropriately considered and taken into account to a sufficient degree?
    d. If not, please explain your answer. For example:
        i. What leads you to think that no proper account was taken of Frederick's particular circumstances? Are there any examples you can provide of a failure to do so?
        ii. What do you think could and should have been done to ensure that those circumstances were recognised, considered and used to ensure appropriate care and treatment?
        iii. If those circumstances had been properly taken into account, in what way do you think the care and treatment of Frederick would (or should) have been different?

    N/A.

47. If they were taken into account, please explain in what way that was done. Are there any practical examples which have led you to think that proper account was taken of Frederick's circumstances? *N/A.*

Safety

For the purposes of these questions, 'safety' is to be interpreted broadly and can mean physical, mental and sexual safety.

While Frederick was an inpatient at any time during the relevant period:

48. As far as you are aware, was Frederick ever subjected to any abuse, physical or sexual assaults (whether from staff or from other inpatients)? If so, please

tell us what you know about that, including as much information as you are able. *No.*

49. You told us in your application for core participant status that in the first week of October, Frederick tried to cut his wrists. Was at Peter Bruff at that time, or at the Lakes? *The Lakes.*

50. Before 4 December 2004, as far as you are aware, was Frederick able to harm himself or make attempts to harm himself while on a ward on any other occasion? Please tell us what you know about each such incident (including the incident you have referred to in the first week of October), again including as much information as you are able. *No.*

51. Did Frederick ever raise fears or concerns with you or with anyone else regarding his safety or that of another inpatient? If so:
    a. Please describe the incident(s) or event(s) that you know about, including all individuals involved.
    b. When did those take place?
    c. When did you come to learn about those incidents or concerns?
    d. From whom?
    e. Were any matters affecting the safety of Frederick or any other inpatient reported, as far as you were aware? If so:
        i. By whom?
        ii. To whom?
        iii. What action (if any) was taken as a result?

    No.

52. If not already included in your answers to the questions above, did you have any concerns regarding any aspect of Frederick's safety while he was an inpatient? If so, please describe:
    a. The nature and circumstances of those concerns and how they arose.
    b. How they came to your attention (for example, were there events that you witnessed, or that Frederick told you about, or that you learned about at a later stage or from someone else).

c. When they happened, or over what period.

No.

53. In your application for core participant status and your email to the Inquiry of 11 September 2024, you explained that your father was placed under various types of formal observation, as follows:
    a. Following his attempt to take his own life on 21 October 2004, he was admitted to the Lakes and placed under 24 hour observation;
    b. On 29 November 2004, this was reduced to 15 minute observations despite it being noted at a review that day that he was not much improved;
    c. When your father died on 4 December 2004, he was still subject to 15 minute observations, but at the Inquest into his death, there was no evidence that 15 minute observations were in fact being carried out;
    d. Staff admitted that they did not always have time to carry out those observations;
    e. When it was noticed that your father was missing, this was only because he had not attended to receive his morning medication, far exceeding a 15 minute time frame;
    f. The person that noticed that he was missing was neither the nurse in charge of observations that day nor the person responsible for observing him that day;
    g. The person in charge of observations had to be found in order to unlock the bathroom door, although staff stated at Inquest that all members of staff had keys.

Is there anything further that you wish to share with us about those matters?

There were obviously many more occasions when observation times were amended over the 5-month period. I was not consulted about any reduction in observation times and these decisions did not appear to correlate with Dads mental health at that time. Not to exhaust the point, but he had not improved and therefore neither had the risk of him harming himself.

On the occasion mentioned above (29 Nov 2004) I did not understand and I am still confused as to why his observation times were reduced; especially as only 5 weeks had passed since he had attempted to take his own life.

The fact that they did not know where he was for an extended period of time only displays the utter complacency and disregard for his welfare. They were clearly not observing him anywhere near within the 15-minute observation timeframe. Stating that they were 'understaffed' is unacceptable in my view. The nurse responsible for observing him that day did not even notice that he was missing. Furthermore, the person in charge of observations that day had no idea where he was or when he had last been checked. The entire set of circumstances that led to my Dads suicide was an utter shambles. There was no recording, management or organisation.

It was noted several times during the Inquest that the rota for observations was changed on an hourly basis and that this was updated on a whiteboard. I recorded that during the statement provided by Dr **[I/S]** *at the Inquest that she had stated that nurses have decision powers to decide the frequency of observations. This is quite troubling to me; surely observation times should be adhered to in accordance with the consultants' decision?*

[I/S] *stated that she let him into the bathroom at 09:15, she stated that at approximately 09:30 he had not responded to a knock on the door and that the alarm was raised although she was not sure who raised the alarm.* **[I/S]** *stated during her statement that she noticed that he was not around to collect his medication and requested that* **[I/S]** *check him. It still unclear as to who actually noticed that he was missing.*

The ambiguity regarding the timeframe of what happened that day is substantiated by the following:

- *According to the statement provided by* **[I/S]** *PC, he and his colleague were informed that "he was determined dead at 1010 hours by a Dr.* **[I/S]** *".*
- *At the Inquest the coroners officer stated that he was confirmed dead at 09:15.*

- [I/S] *stated during the Inquest that she had let him into the bathroom at 09:15 and that approximately 09:30 he had not responded to a knock on the door.*
- *Another witness stated at the Inquest that they noticed that he was missing when he did not turn up for his morning medication. I do not know what time this was. However, they stated that they requested that* [I/S] *attempt to find him.*
- *The final verdict states that "at about 9.30 am....he was found hanging in the bathroom".*
  I understand that time would elapse between finding him and having him confirmed dead. However, these timescales are not at all consistent.

PC [I/S] *reported in his witness statement at the time of Dads death that he had spoken to* [I/S]*, a member of staff at The Lakes Hospital on duty that day. His statement reads as follows: "*[I/S] *stated that there is legislation in force that requires them to record these checks. However, he went on to state that this is not being done and never has been. This is the way things are not only here but at the other NHS trusts in the area". This was not mentioned or highlighted at all during the Inquest.*

Additionally during the statement provided by PC [I/S] *reported that "The door had a locking system from the inside only and required a special tool or screwdriver to open from the outside in emergencies only". This contradicts what* [I/S] *said during the Inquest: I recorded that she had stated that* [I/S] *had to be found and that the* ***keys*** *to the bathroom had to be located before they could enter. It may be nothing, but to me, these details are significant. Had they been able to get to him in a timely fashion, he may have survived. I also noted during the Inquest, that* [I/S] *had stated that all staff carried keys to the bathrooms. This is again another example of contradictory statements between the nursing staff.*

He should not have even had his shoelaces in the first place! They had removed his dressing gown belt, his trouser belt and his mobile phone lead.

PC [I/S] stated in his Witness Statement that [I/S] had informed him that "...belts and shoelaces were only removed on a seclusion due to their human rights." So were they 'selectively' adhering to human rights in this case or were his shoelaces an oversight? To the best of my knowledge, Dad was never placed into seclusion.

54. Were there other periods when your father was subject to different levels of observation? *Answered above.*

55. In your application for core participant status, you told us that despite continuous insistence from you that Frederick was not making any progress, his observation times were repeatedly reduced. Can you tell us any more about the repeated reductions in his observation levels? Or about the discussions you had in which you insisted that he was not making progress? Please provide as much information as you are able.
Answered above.

56. Do you have any other concerns regarding the observations that were in place for Frederick and/or about the way in which those were carried out?

They were present and I knew that they were there during his stay at Peter Bruff. They would interact when appropriate and they would give us space when we needed it. At The Lakes I didn't see anyone specifically observing Dad. They may have been, but I didn't see them.

57. Were there any periods during inpatient stays where Frederick was <u>not</u> placed under observation? If there were:
    a. Do you know why a decision was taken that formal observation at particular short intervals was not needed? What were you (or other family members or friends) told about that, if anything?
    b. Do you have any concerns regarding that decision? If so, please explain your concerns.

No.

58. Do you have any concerns regarding any restrictive practices used during Frederick's time as an inpatient? *No.*

59. As far as you are aware, was Frederick ever subjected to any form of physical restraint by staff? *No.*

60. If he was,
    a. How and when did you come to learn about that?
    b. Do you know when, why or in what circumstances Frederick was physically restrained?
    c. Do you have any concerns regarding:
        i. the restraint/level of force used or
        ii. the basis for using physical restraint techniques?

    N/A.

61. Do you have any concerns, either generally or in relation to specific examples or events, about how risk was managed on the ward? If so, please provide details. *No.*

Leave, Absconsion and AWOL patients

While Frederick was an inpatient at any time during the relevant period:

62. Please tell us about all requests for leave made by Frederick that you are aware of (including the grant of leave for 8 hours to see his daughters on 4 December 2004).

    I did not record every leave that my Dad had during this period of time, (although I am sure that if I had time to trawl through the hundreds of emails that I sent during this period I could probably provide more). Additionally, this all happened over 20 years ago now. The two times that I have found recorded are:

    - *5 Sept – 4 hours leave at home*
    - *Around the end of Sept – he came to ours a couple of days.*

    He did have many more leaves during this period but I did not keep a record because I did not expect to find myself in this predicament.

63. What do you know about how each such request was managed? *Nothing. I was just informed by his partner that he was allowed leave and what time I was expected to collect him.*

64. Do you have any concerns about the handling of Frederick's request(s) for leave? If so, please provide details of these concerns. *I cannot comment on this.*

65. Do you have any concerns about the outcome of any such request? Please provide details of those concerns and the outcome itself, including the effect on Frederick. *N/A.*

66. If Frederick did have periods of leave from the ward, either with you or with other family members or friends, please tell us what you know about how each such period of leave was managed. For example:
    a. What information, if any, was communicated to you (or to those receiving Frederick for leave) about his mental health at the time, for example: his ongoing treatment or medication, what signs or changes in mood/behaviour might indicate that contact should be made with the ward, the findings of any risk assessments that had been undertaken?
    b. How were requests for any such information handled by staff?
    c. Did you feel that the grant of leave was appropriate?
    d. How did the period of leave go?
    e. Do you consider that it was beneficial to Frederick?
    f. If needed, were you able to contact staff to let them know of any concerns, for example about deterioration in Frederick's mental health?

    Like I said above, I was just told to collect him and bring him back within the required timeframe. I was absolutely terrified every time that he was on leave and I could not relax until he was back in the hospital (where I thought that he was safe). I should have been involved in these decisions, especially as 9/10 I was the person taking him out and returning him and regularly spending his leave time with him.

    I was not given any advice or indication of what the staff considered as his current risk level; it was my understanding that he was not getting any

better in the hospital so it was thought that the leaves may help him to improve.

Dad would enjoy the leaves but it would be a massive battle to get him into the car and get him back to the hospital. He would act up prior to leaving and during the journey he would kick the car out of gear while I was driving him back. I was not given an opportunity to speak to anyone upon his return to hospital following a period of leave.

On one occasion I went to collect him from Peter Bruff and he wanted to go home. His partner refused to have him home because she could not cope, so I offered for him to come to mine instead. He became so upset and insulting toward me that I left without taking him. He spent the rest of the day calling me. It put an enormous strain on our relationship and Dad was not acting like himself at all during these times.

67. Are you aware of any instances when Frederick absconded or tried to abscond from the ward and/or of any occasions when he failed to return from leave? *No.*

68. If so, please tell us what you can about each such incident. For example, in relation to any incident of absconsion, attempted absconsion or failure to return from leave:
    a. When did it take place?
    b. What happened? For example, how was Frederick able to abscond?
    c. What awareness, if any, did staff have of events at the time?
    d. What level of observations, if any, was Frederick under at the time he absconded?
    e. How was the absconsion handled by staff when it was discovered?
    f. What action was taken?
    g. Was any action that was taken by staff undertaken in a timely manner?
    h. How, when and in what way did Frederick come to be returned to the ward?
    i. How was his return managed?
    j. What communication, if any, was there with you (or other family members or friends) about what had happened and Frederick's

whereabouts (during, before and after any period of absconsion or any incident of attempted absconsion).

k. Was that level of communication appropriate, in your view?

l. Do you have any other concerns about any other aspect of how an absconsion or failure to return from leave was handled?

N/A.

Transfer

69. We are aware from the information that you have provided to the Inquiry that Frederick was transferred on at least two occasions, first on 20 July 2004 to Peter Bruff immediately following his admission to the Lakes and second from Colchester General to the Lakes on 22 October 2004 following his attempt to take his own life. During the relevant period, were there any other occasions when Frederick was transferred to another unit, ward or facility (even if to a general ward for example, for treatment for physical ill-health)? *No.*

70. Please tell us about the circumstances of every transfer, including, for example:

    a. When it took place

    b. From and to where he was transferred

    c. The reason for the transfer.

    N/A.

71. Do you have any concerns about the basis for the transfer (in other words, why it was done)? Or any concerns about a transfer not taking place, where you consider that it should have done? *N/A.*

72. What information, if any, did you and/or other family members or friends receive about any transfer? Do you have any concerns about what you were told (or not told) by staff? *N/A.*

73. Do you have any other concerns regarding that transfer? If so, please describe your concerns. *N/A.*

Discharge and Continuity of Care and Treatment in the Community

74. We are aware from what you have told us that Frederick was discharged from an inpatient mental health facility on at least two occasions, 20 September and 17 October 2004. In relation to those discharges as well as to any other discharge from a mental health inpatient facility during the relevant period, please tell us:
    a. When was that?
    b. As far as you were aware, what was the basis for the decision to discharge Frederick?

    Dad was discharged from Peter Bruff on 18 September and 17 October. In both cases, I was not involved in any decisions to discharge him so I would not know what the basis for those decisions were. Had I had any input I would have told them that I did not think that it was a good idea, but I trusted the professionals and assumed that they knew what they were doing.

75. What involvement, if any, did Frederick have in:
    a. any aspect of the decision to discharge?
    b. any planning for discharge, formulation of a discharge plan, or arrangements for follow-up care in the community?

    No idea.

76. What involvement, if any, did you (and/or other family members or friends) have in:
    a. any aspect of the decision to discharge
    b. any planning for discharge, formulation of a discharge plan, or arrangements for follow-up care in the community?

    As far as I am aware we were not involved other than his constant request to be discharged. They may have spoken to his partner*, but when it came to discharges she was more candid because she knew that she would need my support. There was never any mention of a discharge plan or arrangements for follow-up care in the community. This terminology and these services are new to me as of now. I didn't know that they existed.*

77. How far in advance of Frederick's discharge date did you (and/or other family members/friends) learn that it was to take place?

I cannot remember. A few days prior to from memory.

78. When you learned that Frederick was to be discharged, was a discharge plan in place? *Not as far as I am aware.*

79. What information was shared with you about the discharge plan and arrangements for care in the community? *None.*

80. In your application for core participant status, you drew the Inquiry's attention to a cycle of short turn-around from high-risk circumstances to reduction in care or discharge, with no progress regarding your father's mental health noted during that time. Is there more that you would like to share with us about that?

As we now know, he was not receiving any psychiatric care and he was not making any improvement. In fact he was getting worse.

During the course of this Inquiry I am still learning what I should have expected to have occurred prior to and after such discharges.

All I can say is even back in 2004 I knew that discharging my Dad at these times was a high risk after such a short period of time and with no progress having been made with regard to the state of Dads mental health. If little old me could tell that he was not safe to be discharged, it begs the question as to the motivation behind such decisions to do so by the hospital.

81. Do you have any other concerns regarding any aspect of the decision to discharge Frederick, the discharge process itself or the way in which it was communicated to those who would be supporting Frederick after he was discharged?

I think that I have covered it. The motivations behind the decisions were questionable, the discharge process and communication did not exist.

82. Did Frederick receive any community-based treatment, care and/or support after he was discharged? *No.*

83. If not, why was that? *I don't know. Perhaps the timescales were too brief.*

84. If he did, please tell us about it. For example, for each such period of community-based care following discharge:
    a. What was that treatment and/or support (including any medication prescribed)?
    b. By whom was it provided?
    c. Did it accord with his discharge plan and any plans for follow-up care that had been made (and if not, how it did not do so)?
    d. How regularly was Frederick visited or offered face-to-face appointments?
    e. How did you (and/or other family members and friends) consider that the treatment or support provided in the community after discharge was working for Frederick?

N/A.

85. Do you have any concerns, comments or observations regarding the community-based treatment or support that was provided (or not provided) to Frederick? If so, please give details. *N/A.*

Engagement

These matters might have been covered by you in answer to other questions within this letter. If not, thinking about the entire period of time between a mental health assessment leading to admission as an inpatient (or a failure to assess or to admit) through to Frederick's death (including periods of leave, discharge and any treatment or care provided in the community):

86. To what extent was Frederick involved in and/or informed about decisions relating to his care and treatment? *I do not know.*

87. Do you consider that that level of involvement was appropriate? In what way was it appropriate or not? Please explain your views. *N/A.*

88. Thinking about the same period of time, what can you tell us about how staff, healthcare and other professionals communicated and engaged with you and/or other family members or friends? For example:
    a. To what extent were you involved in decisions relating to his care and treatment? This can include decisions about Frederick's physical health as well as mental health care and treatment.
    I wasn't apart from the one meeting as mentioned above.
    b. To what extent were you able to input into those decisions, for example by providing information about Frederick's history or character? *I wasn't.*
    c. Do you consider that you were listened to? *Not at all.*
    d. To what extent were you informed about decisions relating to Frederick's care and treatment? *I wasn't.*
    e. Do you have any concerns regarding the extent to which you and others in his support network were involved?
    I have mentioned that his partner *seemed to be the point of contact, although the information that she divulged to me was minimal. As I have stated previously,* **[I/S]** **[I/S]** *I would have done anything to assist and provide insight and feedback had anyone listened to me. My only motivation was to get Dad better again. I should have been listened to and I should have been kept in the loop with regard to everything. As I believe I have previously stated, we were not aware of 'care plans' or any of the terminology that I have since learned during the course of this Inquest.*

    I understand that they did not have either the time or the resources available to listen to each and every member of a patients support network, it would also become rather confusing. However, in this instance there was primarily **[I/S]** *and I that were involved on a regular basis.*

Now, coming to the 'next of kin' term. I have something to say about that. I was considered important enough to sign the papers the day that he was sectioned and they all knew who I was and that I visited nearly every day, but when it came to discussing any of Dads care, treatment etc. I was excluded. It still confounds me to this day. They understandably spoke to [I/S] *because she was his partner* [I/S] [I/S] [I/S] *. If I was not his next of kin, which I am assuming that I wasn't, then when I signed the papers to have Dad sectioned, did that compromise the validity of the sectioning?*

89. In your application for core participant status, you explained that despite continuous requests by you for information regarding your father's care, you were infrequently updated. You also explained that that was the case despite you making clear to staff that your father's partner was not his wife and that you should be consulted in all matters regarding Frederick's care.
    a. Was it the case during every inpatient stay, both at the Lakes and at Peter Bruff, that you received updates infrequently?
    From his consultant? Yes it was. I at least had conversations with the lead nurse and the nurse who primarily observed Dad during his stay at Peter Bruff.
    b. Is there any more that you would like to share with the Inquiry about that?
    I was completely left out of the loop once I had signed the papers to have Dad sectioned. The only information that I could glean was during conversations with the nurses at Peter Bruff. Requests to speak to his consultant / psychiatrist were ignored. I only remember 2 -3 occasions when I actually spoke to her personally.
    Although he had a partner at this time, she was emotionally incapable of coping with the entire situation which is why she requested my assistance in the first place. As time went on, her interest in his care and overall well-being decreased [I/S] [I/S]

[I/S]

[I/S]

My Dads health and well-being was my only concern. I should have been the one that was involved with the entire process from the moment that he was sectioned. It should have been very obvious to them that I was the one with all of the concerns and I believe that they avoided me and took the 'easy option' so that they did not have to answer my questions. [I/S]

[I/S] *It's much easier to manage a family member who is not really interested than one who is committed to ensuring the safety, care and recovery of the patient.*

Had they actually taken the time to speak to me they would have learned that despite Dads little acts of appearing better, I knew that he was saying and doing whatever he had to so that he could be discharged. I would also have been able to provide them with insight into the extent and severity of his illness by explaining how he was prior his breakdown; they did not know what Dads 'normal' was. I would also have been able to provide insight into his past and how his illness had progressed and presented itself prior to admission.

90. You also told us in your application for core participant status that you sent your father's psychiatrist some notes that you had made regarding his illness and that a witness informed you that on receiving the document, the psychiatrist laughed. Is there more you would like to share with the Inquiry about that?

I actually still have a copy of the covering email and letter that I sent. Due to the fact that I could not get in contact with his psychiatrist / consultant and the fact that he was getting worse, not better, I felt that the only way that I could get my voice heard was by sending an email. I was under the assumption that because he was in a mental health hospital, that he was receiving psychiatric and therapeutic treatment. With this in mind, I was

concerned that perhaps he was not opening up to them; he was after all, a man of a certain age and generation. I believed that I may be able to provide information that may in some way assist them in his care.

The document outlines what I considered to be the key triggers, what I perceived to be his current feelings from the many conversations that I had had with him and his feelings about the sectioning. I also included a list of key phrases that he continued to repeat. I did not in any way consider myself to be a professional. However, Dad and I were extremely close and I knew him so well. [I/S] *later mentioned to me that Dr* [I/S] *had said that she had received my document and proceeded to laugh, although upon reflection now,* [I/S] *was probably not the most reliable source of information. Dr* [I/S] *did not discuss or respond to my email.*

In retrospect, I now realise how desperate I must have been to go to such measures. I was working long hours and then driving hours and spending time with my Dad, despite my exhaustion and heavy workload both in and out of work, I found that the only way that I could communicate with Dr [I/S] *was via email and a document. I was only trying to help. I felt belittled and ashamed of my document.*

91. When he was an inpatient:
    a. Were you able to contact Frederick when you wanted to? *Yes. I could call his mobile.*
    b. Were you able to visit when you wanted to? *Yes.*
    c. Could Frederick contact you? *Yes.*
    d. Were you able to pass information to or seek information from staff on a regular basis? *No.*
    e. Do you have any other concerns about the extent to which you (and/or other family members or friends) were able to
        i. Make contact with Frederick and/or
        ii. Provide or receive information about him?

No. I think that I have covered it.

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

Please note that these questions are separate from questions about investigations and other proceedings, such as an Inquest, which are dealt with later in this letter.

When Frederick was an inpatient:

92. Were you (and/or other family members or friends) given any information at any time about how to raise concerns about Frederick's or any other inpatient's safety? If so:
    a. Who provided that information to you?
    b. What was it?

    No.
93. Did Frederick, you (and/or other family members and friends) raise any concerns or complaints (whether in a formal or an informal way) about any aspect of the care and treatment of Frederick, including, but not limited to:
    a. His (or other patients') safety, including in relation to self-harm
    b. The conduct of staff or of other patients
    c. The number of staff on the ward
    d. Observations and checks
    e. Restrictive practices or physical restraint
    f. Therapeutic care
    g. The ward environment
    h. Clinical treatment decisions?

    No.
94. If concerns or complaints were raised about those matters or any other aspect of the care of Frederick as an inpatient, please tell us in each case:
    a. When was that?
    b. What was the nature of the complaint or concern? What had led to it?
    c. Who made the complaint or raised the concern?
    d. To whom?
    e. What was the response? What action (if any) was taken?

N/A.

95. Did Frederick, you (and/or other family members and friends) raise any concerns or complaints (whether in a formal or an informal way) about any aspect of the care and treatment at **any other stage** of Frederick's mental health treatment (i.e. when he was not an inpatient) including for example assessment, admission or care and support in the community after discharge? If so, please tell us about that, including the following details:
    a. When was that?
    b. What was the nature of the complaint or concern? What had led to it? Who or what was it about?
    c. Who made the complaint or raised the concern?
    d. To whom?
    e. What was the response? What action (if any) was taken?

    No.

96. What is your impression of the way in which any complaint or concern raised was handled? For example:
    a. Was an adequate and appropriate response received?
    b. Was that done without delay?
    c. Was the action taken (if any) sufficient and appropriate?
    d. Do you have any concerns regarding the way in which any complaints that were raised were handled?

    N/A.

After Frederick's Death

97. What were you told, if anything, about processes that would take place (for example internal investigations or an Inquest) and how matters would be handled? *Nothing.*

98. Was any support offered to you (and/or to other family members and friends) after Frederick died, either in the immediate period after he died or at a later stage? If it was:
    a. Who offered that support?
    b. What was it? What did it consist of?

c. When was it offered?
d. Did you take up any support offered?

Not as far as I am aware.

99. Do you have any comments, concerns or observations in relation to how you were communicated with, treated and supported after Frederick died?

There was absolutely no communication or support.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

100. After Frederick died, were any investigations undertaken by or arranged by the Trust or any other relevant mental health provider?

I was informed by my solicitor that there had been a police investigation following Dads passing and that there would inevitably be an investigation by the coroner and that my answers would be met during the Inquest.

I only found out about the HSE investigation in early April of this year thanks to the Lampard Inquiry. I have recently read the statement from THE TRUST by Paul Scott within the Core Bundle (pg. 24, Point 23, b). I originally stated to yourselves that I had not been aware of any internal investigations following Dad's death. It was not until 13 May 25 that I found files containing past information that I had forgotten that I had kept. Within these files I found the Executive Summary of the SUI Report that was given to me prior to the Inquest.

So yes, there was an internal investigation following Dads death and I surmise that the information pertaining to Dads case in Paul Scotts statement contained within the Lampard Inquiry is based upon the information contained within this report. I would like to add that in my opinion, the information within this statement is contradictory and mis-leading. Whether it is significant or not I do not know, but I will provide my

input regarding the SUI Executive Summary. ***It should be noted at this time that my notes from the Inquest included admission of lack of resources to provide psychiatric care.***

- ***SUI Executive Summary (the only part of the document that I was provided access to in the weeks leading up to the Inquest)***
    - *"….Mr Frederick Peck demonstrated a sustained level of risk of suicide throughout his involvement with the Trust's services".*
    - *At the time of the incident the clinical team were sufficiently optimistic about Mr Peck's progress that they granted him up to eight hours accompanied leave with family members. The Panel felt this to be technically appropriate"*
    - ***The two statements above are utterly contradictory.***

  "The Panel concludes that no omission or action contributed to the incident". ***The following statements within the SUI Summary contradict this conclusion:***

    - *"The panel acknowledged that there is no clinical psychologist or psychotherapist based at the inpatient unit or allocated to the ward. It remains an open question whether easy access to psychological treatments on the ward would have helped Mr Peck to enter into a trustful therapeutic relationship, that might have enabled him to address his difficulties in relationships and his traumatic past experiences".* ***I noted during the Inquest that Dr [I/S] had stated that psychological care may have helped had it been available and that it had not been available due to lack of resources.***
    - *"As the Nursing Observation Policy was used in The Lakes at the time the Panel had some concern regarding the task orientated nature of carrying out periodic checks. It is clear that Mr Peck used the 15 minute period of time between checks to take his life".* ***Nowhere within this statement does it mention the white board system, the confusion***

regarding when he was checked or the resource issues that were raised during the Inquest.

- *"It is clear that the ligature point was identified by the Risk Management audit. Staff were not aware of the risks posed by the exposed pipe and bracket as they were not aware that it had not been appropriately secured during the remedial work. It is of concern that the work concluded leaving this pipe exposed. It may have caused staff to develop a false sense of security and making assumptions that all ligature points had been dealt with."*

Having read the admissions from the panel above, I will remind you again that it was stated that "no omission or action contributed to the incident". I personally find this statement impossible to accept.

- *"It is the opinion of the Panel that it is impossible to mitigate all ligature points. However, given the determined desire by Mr Peck to take his own life, it is impossible to conclude if he would not have chosen to take his life outside of hospital or by some other method. It is important to note he had made a serious suicide attempt on 22nd October 2004 while on leave."* ***This point really highlights the culture and attitude that I was faced with at this time: that he would have probably done it anyway and that I was making an unnecessary fuss over something that would have inevitably happened... I did not accept this then and I do not accept this conclusion now. It is also a fine example of The Trust brushing over the fact that they allowed someone that they considered a 'high risk patient' to enter a bathroom containing a ligature point that had been identified as a risk, when the "high risk" patient had attempted to hang himself 5 weeks prior to this incident.***
  It was stated that "considered approach to risk was evident". This does not correlate with previous statements or the facts and final outcome.

101. If so, please tell us what you know about any such investigation, including:

a. By whom was the investigation carried out?
b. Was the investigation undertaken promptly?
c. How long did it take?
d. To what extent were you (and/or other family members or friends) involved in or updated about the progress of the investigation?
To the best of my knowledge I have answered this question above. I did not know when these investigations were held, I do not know how long it took and I was not involved in these investigations.

102. What was the outcome or the findings of the investigation? For example:

a. Were any failings identified? If so, what were those?
Forgive me if I repeat myself with some of these statements. ***I would also like to add at this moment that I was only provided with the Executive Summary of the SUI so I can only provide the information contained within the 3 pages that I have.***
The only true admission of failings that were recorded in the Executive Summary of the SUI as:
    - *"A ligature point audit was carried out on the ward. The ligature point was identified and an action plan was developed. Unfortunately, this ligature point was not removed as part of the remedial work until after the incident".* ***"Unfortunately, my Dad hung himself"...***
    - *"The panel acknowledged that there is no clinical psychologist or psychotherapist based at the inpatient unit or allocated to the ward. It remains an open question whether easy access to psychological treatments on the ward would have helped Mr Peck to enter into a trustful therapeutic relationship, that might have enabled him to address his difficulties in relationships and his traumatic past experiences".* ***This is an ineffectual statement. During the Inquest, I noted that Dr [I/S] stated that psychiatric care could have helped my Dad. After much pressing from my barrister, she admitted that he did not receive psychiatric***

care due to resource issues. The statement above, does not in any way address a resourcing issue.

b. Did you agree with the findings?
No. Answered above.

c. Was a report produced? (This might be, for example, a Root Cause Analysis or Serious Incident report).
I am only aware of the Serious Incident Report.

d. Was a copy of the report provided to you?
Thanks to the determination of myself and my solicitor, we obtained at least the Executive Summary just before the Inquest was due to commence.

e. What were your impressions of the report in terms of both its findings, and its adequacy and accuracy?
Answered above.

103. Do you have any comments, observations or concerns regarding any investigation or related report and findings that you would like to share with the Inquiry?
With the limited access to information that I was granted, I have commented on what information I was provided with.

Other investigations or legal proceedings

These questions relate to investigations by organisations **other than** the Trust. These may include the Inquest, criminal investigations, or investigations by the Care Quality commission.

104. What were you told about the process for any external investigation into Frederick's death? *Nothing.*

105. From whom did you request or receive that information? *I did not request information. I was not aware that I could and I was grief-stricken. My world had just fallen apart.*

106. What level of involvement did you (and/or other family members or friends) have in any such investigations or legal proceedings? *None.*

107. In relation to the Inquest into your father's death, you have told us that:

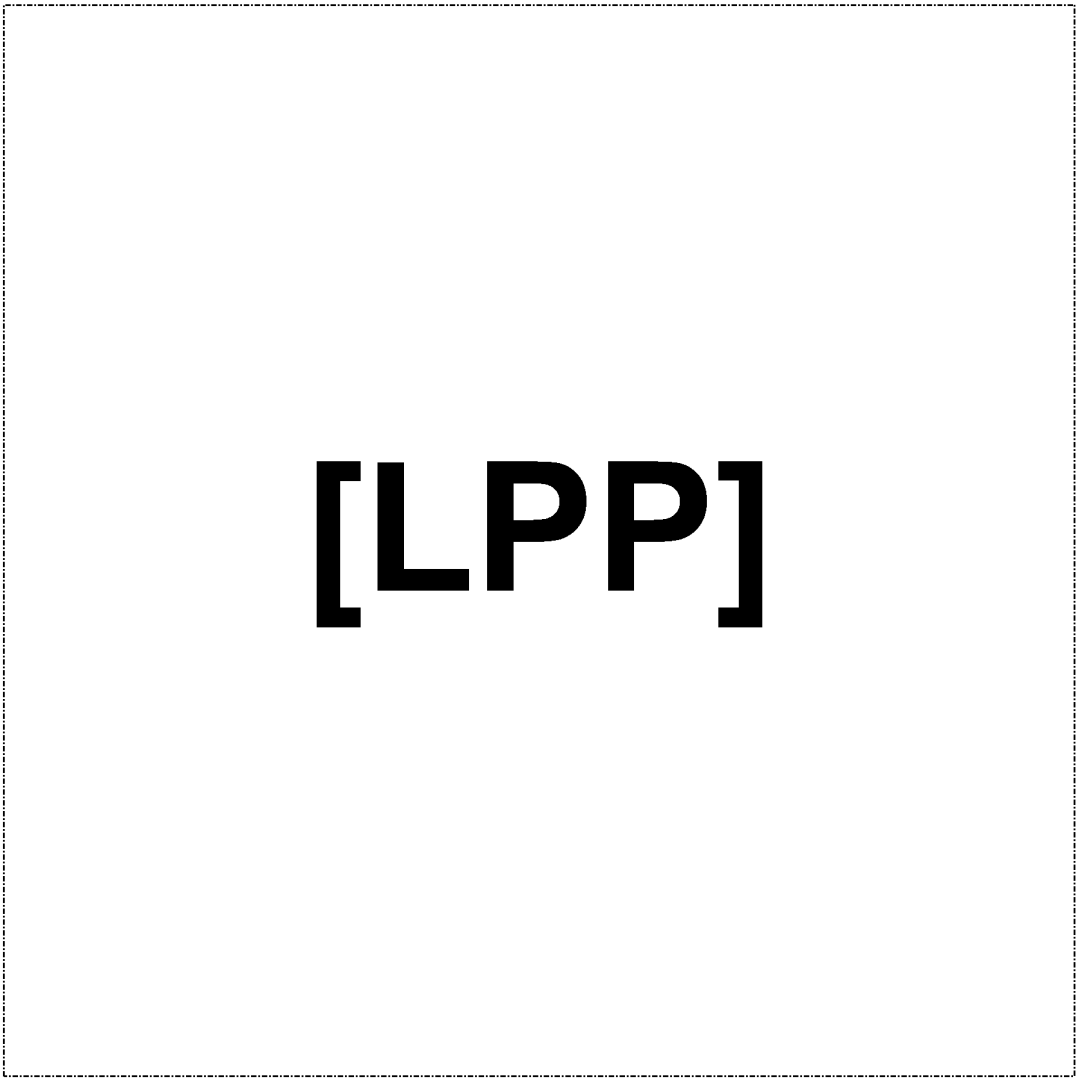
a. The Inquest did not take place until 24 May 2006;
b. Disclosure of documents from the Trust to your legal representative did not take place until an hour before the Inquest, and the documents received were incomplete;
c. The main witnesses were not called to give evidence at the Inquest; I believe they were eventually called because the Inquest was held over two days to allow The Trust to make arrangements for the key witnesses to attend. This was only because I demanded that his happen via my barrister. We had previously been informed by The Trust they key witnesses were unavailable.
d. The staff member who was responsible for conducting 15 minute observations on your father on the day that he died was on holiday;
e. The Trust was hesitant to agree to the attendance of key witnesses;
f. The statements from the nurses on the ward on 4 December 2004 were contradictory and inconsistent;
g. The Inquest was a painful process for you and by that stage you had lost faith in the system as a whole;
h. You felt that you were ignored and treated appallingly;
i. You felt that efforts were being made to brush your father's case under the carpet;
j. You consider that without a legal representative, you would have received no response or explanation from the Lakes.

Is there anything more that you would like to tell us about any of those matters?

I must note at this time that I have come to the realisation that this process was just as emotional and traumatic as when Dad was poorly and when he died. It is just as difficult to re-visit this moment in time as it was those moments in time.

I have covered a lot of the points above in previous answers so apologies if I repeat myself.

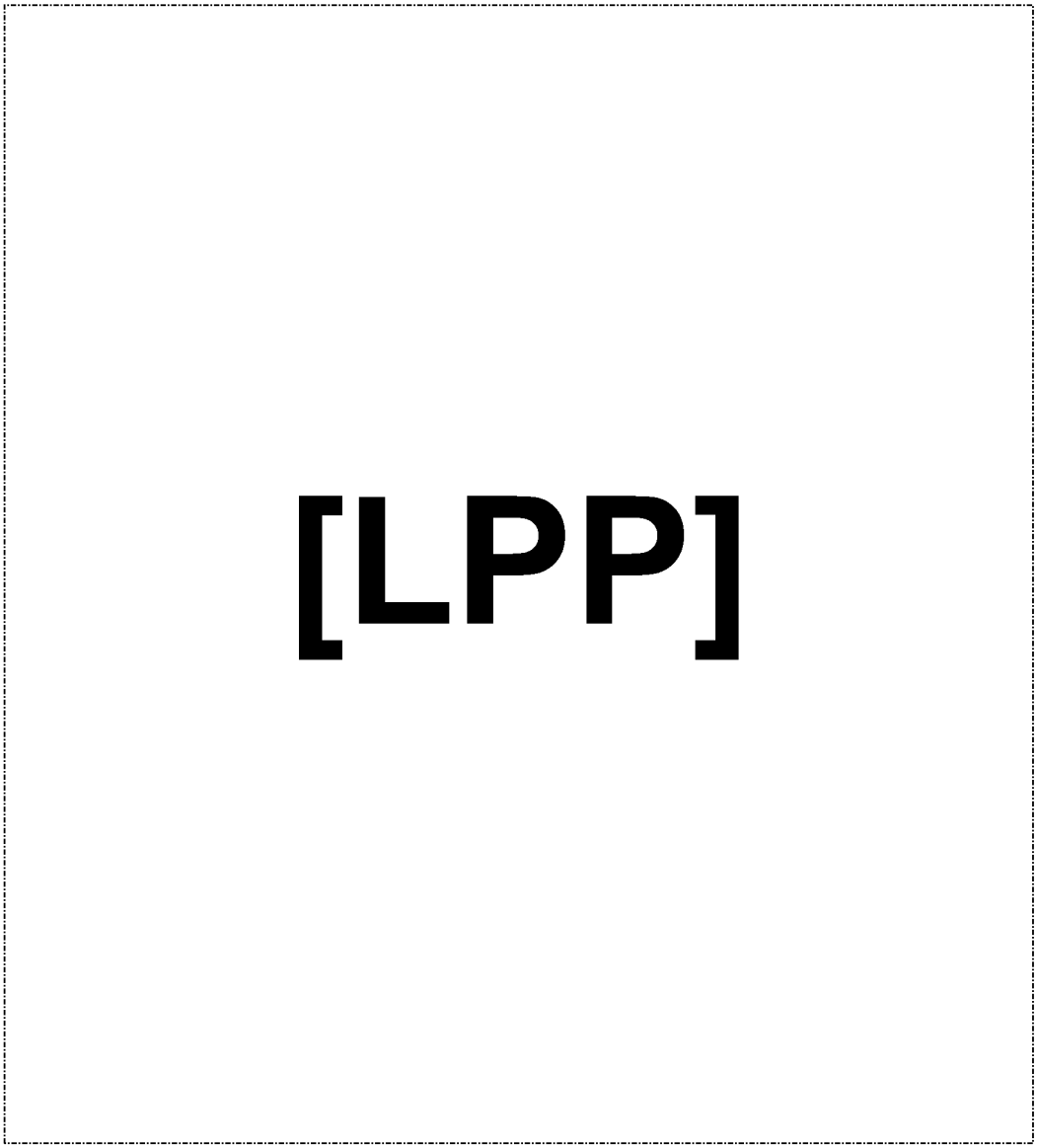
It was harrowing from start to finish. I came out of the Inquest without having any of my questions adequately answered. The entire Inquest was a shambles. Every question that I asked via my attorney was met with evasive non-committal responses that were not substantiated with any factual evidence and did not at all adequately answer any of my questions. I would also like to point out that it cost me thousands of pounds in legal fees to get what were at best, half-answered questions. I had to come to terms with the fact that they did not know what had actually happened that morning leading up to my Dads death, so there was no hope of me ever finding out. Even my attorney was shocked by the utter evasiveness of The Lakes representatives.



[LPP]

[LPP]

This is a clear example of the reticence of both the coroner's officer and the Trust to provide us with any information pertaining to Dads case. I can assure you that any "reasons revolving around my welfare" or "controversial material" cannot begin to compare with what my imagination can torment me with still to this day. Whatever the reasons or controversial material may be, I will process and cope with. What I cannot cope with, and what continues to cause me anguish and a lack of closure to this day is the unknown.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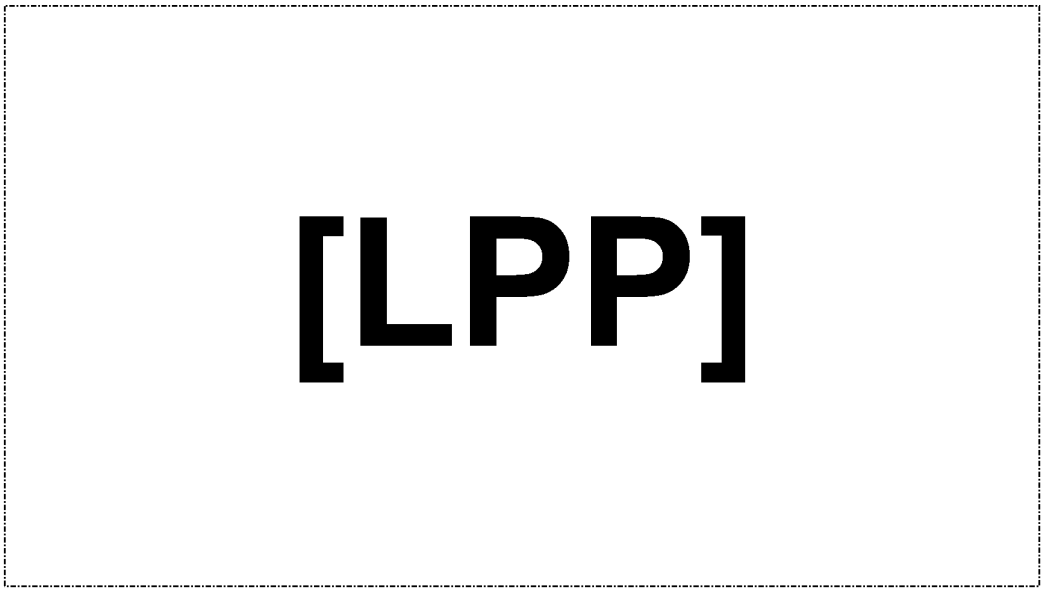
[LPP]

[LPP]

[LPP]

It speaks for itself really.

108. In terms of the evidence heard at Inquest and the conclusions, you also told us in your application for core participant status that:

a. A risk assessment had been carried out in June 2004 identifying the ligature point as high risk;

b. During the Inquest a representative of The Lakes Hospital admitted negligence in

i. not identifying the risk in earlier assessments

ii. not rectifying it or checking that it had been rectified and

iii. not highlighting the potential risk to the nurses on the ward.

c. All that your family received was a forced apology and promises that the Trust would learn from its mistakes and make improvements to ensure that this did not happen again;
d. You consider those to have been false promises.

Is there anything more that you would like to tell us about any of those matters?
We have proof that my concerns that the promises made by the representatives of THE TRUST were false; due to the continued inpatient deaths that occurred following my Dads passing. At the Lakes hospital alone, during the applicable timeframe of this inquiry, there were 3 more inpatient deaths and 1 near-miss by hanging at The Lakes hospital alone. This does not even cover any other fatalities that occurred during this time.

109. Is there anything more that you would like to tell us about the conclusions or findings of any investigations (for example, the conclusions recorded by the Coroner's Inquest or recommendations made), about your own impressions and experiences of those investigations or proceedings, or about the level of support offered to you during them?

Well first of all, I was not offered any support. I had to seek my own legal advice and research the entire process on the internet prior to the Inquest.

It has become evident to me during the process of completing this form that I believed that the only way that I could obtain any answers pertaining to my Dads death was during the Inquest. I have found several emails that I sent during the time leading up to and following the Inquest which have provided me with some insight into who I contacted and what was discussed. I am not sure how relevant they are now so I will not include them in this questionnaire. As I have already mentioned, I employed a solicitor and barrister during this time. I also contacted Inquest and the legal team at Mind. Both organisations provided me with information and reference points for further information.

Dad's partner attended a meeting with the coroner W/C 11 April 05 to provide a statement. Although I was not invited, I did attend and expressed my opinions and expectations at this meeting. I wrote a document to the

coroner following this meeting, but it appears that I decided not to send it because it was too emotional and in my words at the time 'I did not think that it would add any value to the process' following advice from my solicitor. I still have a copy of the document. Although it is a moot point because sadly, I do not have any record of having ever sent it, it does give an insight into my concerns and opinions during this time.

On 26 Jan 06 I report that at around this time I had heard from the coroner and that he had informed me that the NHS board had taken since April 05 (8-9 months) to provide a basic report and that they had still failed to provide key witness statements. By this time, over 16 months had passed since my Dad had died.

It should be noted that by this time I had waited patiently for his autopsy and for his body to be released, viewed his body in the Chapel of Rest, organised and attended my Dads funeral. By the time that the Inquest was taking shape and being organised, **[I/S]**

[I/S]

The final verdict was: on 4th December 2004 at about 09:30 at the Lakes Hospital in Colchester Frederick James Peck was found hanging in the bathroom. He killed himself whilst suffering from psychotic depression.

Following a lot of questioning, it was said that he had been observed at 09:15, although there was no evidence to substantiate this statement and previous statements had contradicted this time. I am not sure as to where the "09:30" time came from because from memory, the time that he was found well-surpassed this. In any event, how does any self-respecting Coroner accept and decide on a verdict in such a case that involves the phrase "at about 09:30"? I believe that 09:30 suited everyone because it fell within the 15 minute observation time that they were supposed to be adhering to. The timelines, observations and what happened when they discovered that he was missing, were consistently contradictory and confusing in all of the witness responses.

Yes, he did hang himself while suffering from psychotic depression (apparently). But WHY was this allowed to happen? How was this not at the very least "contributed to by neglect" following admissions of the failures that I have already previously detailed?

I was messed about from start to finish and the entire process went on for far too long; only extending my grief. I was not supported in any way. During the Inquest, I felt like I was making a fuss unnecessarily and 'putting everyone out' by asking questions.

It is evident that during that time I felt that I did not have any power to complain or request details over a year after my Dads passing at the Inquest. I was informed by my solicitor to expect answers to my questions during this process. This did not happen.

I have had to accept that I will never get an accurate and succinct account of what actually happened on the morning of my Dads death and I will never receive the information that I need to fully achieve closure to this, the most horrific, traumatic and tragic chapter of my life.

It felt to me that everyone else appeared to have the attitude that he would have done it anyway at some point. This was not my opinion and to me such an attitude was not acceptable in 2004 and it is not acceptable in 2025.

Your Views

110. Is there anything positive that you would like to tell us about any aspect of Frederick's mental health treatment? For example, were there any examples of good practice that you witnessed, or aspects/periods of Frederick's treatment that you considered to be appropriate treatment and support? If so, please provide details of those examples.
Only the two nurses that were present during Dads stay at Peter Bruff.

111. Did Frederick ever raise concerns with you about any aspect of his treatment or his time as an inpatient? If so, please explain what those concerns were in as much detail as you can.
No. He was too poorly and really didn't care anymore about anything.

112. Did any other individual or organisation ever raise concerns with you or with anyone else about any aspect of Frederick's care or treatment? If so, please explain the nature of those concerns, including when and by whom they were raised, in as much detail as you can. *No.*

113. If you have not already done so in answer to the Inquiry's questions within this letter, please tell us everything that you were concerned about in terms of Frederick's mental health treatment. This might include information about what you consider to be the most serious failings in his care and treatment. *I had nothing to compare it to.*

114. What do you think should have been done differently in Frederick's case?

- *Outpatient care – from my records and memory he resorted to private mental health care. This may be due to the time that it happened (i.e. in 2004 mental health was not discussed), but we were not made aware of any NHS outpatient care that may have been available. Dad would have taken the NHS care rather than having to pay privately; he was very financially astute.*
- *Education to families regarding the care available and the process.*
- *More support and outpatient care to avoid sectioning – better education from GPs etc. as to services available.*
- *More communication with both the patient and the family at the point of admission and throughout the entire time in hospital.*
- *Clear or even an indication of a diagnosis.*
- *Communication with families regarding the patients' history and their perceptions of the patients' on-going mental state.*
- *Communication of the care plan and the treatment received.*
- *Transparency of information throughout the entire process.*
- *Improvement of risk management and overall processes.*
- *Accurate recording of data.*
- *More empathy toward patients and family members.*
- *Therapeutic treatment must not be compromised by staff shortages.*
- *Psychiatric care must not be compromised due to staff shortages.*
- *Observations should not be compromised due to staff shortages.*
- *Inquests should be held in a timely fashion.*
- *Family members should be supported during the process following a patients' passing.*

- *Family members should be entitled to honest and transparent information regarding any failures to allow grieving and closure to occur. It does not have to be a blame culture that we are creating.*
- *The family needs to be reassured that lessons have been learned and that future families will not have to go through the same despair.*
- *Respect should be shown to a patient when a particular treatment becomes distressing i.e. ECTs in my Dads case.*
- *The outcomes of risk assessments must be closely monitored to ensure that risks are mitigated when identified. 'Recommendations' is not good enough.*
- *There should be accountability when appropriate, but at the avoidance of becoming a 'blame culture'; this helps no-one.*
- *Lessons should be learned. I was told that after the Inquest that they had already made changes. This was clearly not the case. A further 3 people hung themselves at The Lakes Hospital during the time period covered by this inquiry and another person nearly died. This is only hanging instances I should add.*
- *Covering up failings only increases the distress of an already grieving and highly distressed family. The family should be the priority, NOT the hospital.*
- *The hospital environment needs to be more welcoming and nurturing.*
- *There needs to be a solid foundation of communication regarding plans for leave, transfers and discharges.*
- *There needs to be support and care plans in place prior to any of the authorised leaves and transfers. Family members must be supported, consulted and informed of all support and care plans prior to any leaves or transfers.*
- *There should be communication with the family prior to discharge.*
- *The outcome of any investigations should be disclosed to family members to assist in the grieving process.*

- *Regular assessments should be carried out to ensure that any findings from any investigations are addressed to avoid harm to further patients.*
- *The Hospital should make a proper apology.*
- *Families should be informed of their rights from the get-go. I did not know that I could complain while he was in hospital and quite frankly, I didn't know who to complain to. Following Dad's passing I was informed by my solicitor that I could not make a civil claim. I would most definitely have made a civil claim had I been able to.*
- *Staff need to be better supported to avoid emotional burnout leading to complacency and lack of empathy.*

115. Looking at the Inquiry's Terms of Reference [here] and List of Issues [here], are there any other issues that you would like to raise with the Inquiry or that you think the Inquiry should investigate?

- *With reference to Point 4 of the TOR – I would like to ensure that any recommendations put forward by the Inquiry are thoroughly addressed and resolved so that this does not continue to happen.*
- *With reference to point 7 of the TOR – the data provided is incomplete. I kind of understand the complexities surrounding recovering the data, but ultimately, it is not good enough and they have to do better – now and in the future.*
- *I have only had time to read up to the statement from Paul Scott in the Core Bundle with regarding ligature risk assessments thus far. This is a completely mis-leading, inaccurate, blind-siding approach that I have become accustomed to from The Trust. Without the feedback of Core Participants such as myself on such matters, we are still silenced and The Trust will continue to brush over their failings. This is missing opportunities for improvement in the future. We are all families who have had to come to terms with the fact that we will never know the full picture of what happened to our loved ones while under the care of The Trust. We have nothing to gain from apportioning blame now. However, I cannot stress enough the importance of honesty, transparency and the acknowledgement of*

failures for us. The validation of our concerns and the acknowledgement of failing is key to closure because it means that hopefully this will not happen to anyone else.

- *With reference to point 6e of the List of Issues – it is evident to-date, there is nowhere near 'parity of esteem' between mental and physical health care and treatment in Essex.*
- *I would like to know the answers to many of the points raised in the List of Issues in relation to my Dads case, but I understand that this is not the purpose of this Inquiry and that I will never receive any answers or proper closure.*
- *With reference to point 43 of the List of Issues – there does not appear to have been any 'continuity of care' following my Dads transfer from Peter Bruff to The Lakes.*
- *It is clear to me that the internal investigation following my Dads death was biased, defensive and not at all the truth of what actually occurred. Therefore, I would suggest that internal investigations are not sufficient in such cases and that external investigations from an independent body should be carried out in parallel. I would also like to add that investigations into such deaths should include contributions from the family of the deceased to provide a full and comprehensive picture of the case.*

116. The Inquiry is aware that you may have a number of documents in relation to Frederick's mental ill-health, care and treatment. At this stage, the Inquiry would be grateful if, **instead of providing those documents, you could list them in your witness statement**, providing identifying details such as the date and title of the document. (For example: Serious Incident Report dated X; Letter from GP to X dated Y about a change in medication; Medical records dated between X and X.)

I have found hard copies of the following:

- *Witness Statement of PC* [I/S].
- *Witness Statement of PC* [I/S].
- *Witness Statement of* [I/S].
- *SUI Executive Summary.*

- *Care Plan Progress Notes (24 Oct 04 – 6 Dec 04). I cannot find the emotional strength to read this at this time.*

Since conversations with yourselves (The Lampard Inquiry), I contacted The Trust in March of this year to re-request Dads records. I have been informed by The Trust that I need to provide them with 'A copy of the patients' Will, naming you as Executor, or a Grant of Probate document or Letters of Administration'. I do not have any of these. The only living Executor to my Dads Will (my Aunt) has requested these records on my behalf. I will forward this information to you when I receive it. My aunt received the following in an email from The Trust:

"Whilst the Trust will endeavour to answer your request within the permitted timescales, this may be delayed due to urgent operational responses dealing with current Public Health priorities. We apologise for any inconvenience this may cause, we do remain committed to responding to your request and will respond as soon as we are able. Should our response to your request breach the statutory timeframe and you remain unhappy with our response you have the right to complain to the Information Commissioners Office and you can contact them at"...

117. If you are aware of documents that you do not hold, that you think the Inquiry should review relating to Frederick, please provide identifying details for the document(s), who or what organisation you believe holds them and briefly explain why it is important for the Inquiry to review them. *I have no idea!*

Recommendations for change

118. Are there any matters that you have not mentioned in your witness statement so far and that you consider the Chair should take into account when she writes her report and makes her recommendations?

The issue that has stood out most to me while completing this questionnaire has been that I did not know my rights as a key member of the family. In fact, I still do not know what my rights were and are. I still feel that I am 'not valid enough' to provide this statement because his partner was presumably considered to be his 'next of kin'. I was / am insignificant. Therefore, my recommendation would be that concerned family members / support structure members should be informed of their rights from the moment that a patient becomes unwell and throughout the entire process, even if God forbid, the patient dies while under the care of the NHS.

There does not appear to be a clear path for family members to complain. Furthermore, how are family members / support structure members expected to complain when we have no education as to what level of care and support that both the patient and ourselves are supposed to receive? For most people in this scenario, myself included, this was an utterly traumatising and unfamiliar landscape to navigate.

My Dad passed away over 20 years ago now. During the duration of this Inquiry thus far, I have found it alarming that during this time, not a lot has changed and that the same mistakes and failures are continuing to this day. How on Earth has this been allowed to continue for so long?

The Core Participants such as myself (i.e. a family member of a deceased patient) will never receive any closure. We have nothing to gain from re-living what was an absolutely devastating moment in our lives. We will never know the full details of how our loved ones became so ill and were able to kill themselves while under the care of The Trust because this is understandably not within the scope of this Inquiry. Additionally, and sadly, it seems that I am not the only one that has actually had to get 'used to' the evasive and defensive behaviour of The Trust when requesting information. Please ensure that families are at the very least provided with the transparency and honesty that they are entitled to. Please do not allow this entire excruciating process to have been in vain.

It must not be forgotten that behind every statistic and piece of evidence provided during this Inquiry, there has been a patient in crisis who has suffered and died and left behind heart-broken loved ones.

119. Are there any recommendations that you think the Chair should be considering making at the conclusion of this Inquiry?

It is not the responsibility of family members to know what the process is when a loved one is in crisis. There must be better education and support from initial consultation with the GP or crisis team and throughout the entire process.

It is not the responsibility of the family members to complain or highlight the failures of The Trust and similar organisations. Neither is it the responsibility of loved ones to ensure that any complaints, concerns or issues are managed and dealt with. This extends right through to the process following an inpatient death while under the care of THE TRUST.

I would like to refer to Sir Robert Behrens CBE statement on 6 May 25 at the Inquiry, when he highlighted that unless a deceased patients family made and escalated complaints, the Ombudsman would not be informed of such cases. Sir Robert Behrens also highlighted the confusing landscape that loved ones were faced with when attempting to make a complaint. This needs to be improved, but the ultimate responsibility and management should not fall to the families. ALL fatalities should be independently and thoroughly investigated, and this information should be made available to the public. In my humble opinion, this information is of public interest.

120. What changes would you make to any part(s) of the mental health system, or to the system as a whole, in order to bring about lasting and meaningful improvements?

At the time of writing this, according to the NHS England website, "1 in 4 adults and 1 in 10 children experience mental illness". Considering the current political, economic and technological complexities that every individual in the country is facing, cases of mental health issues are inevitably increasing. Mental Health issues are not going to miraculously go away; they are only going to increase in number and severity.

It is evident that very little has been changed or addressed in the 20+ years since my Dads passing. Society has moved along a little bit; we now have mental health awareness days / weeks and we discuss mental health a little more openly than we did. We still have a long way to go however, before we accept that mental illness is the same as any physical illness. Sadly, there is still a social stigma associated with mental illness all of these years later (I have multiple personal examples of this and I am sure that anyone reading this does).

While society catches up, the NHS needs to ensure that its mental healthcare system is at the very least, to the same standard of practices, processes and procedures as the physical healthcare system and that a patient and their families can expect the same quality of care, treatment, transparency and compassion. In order for this to happen, we, the public, need to have reassurance that the Government is no longer going to stick its head in the sand and pretend that this is not happening. It has managed very well at blind-siding and ignoring the catalogue of reports and concerns presented to them to-date. If real change is going to occur it must come from the top-down. We need to see a sincere commitment from the Government to ensure that it is invested both financially and practically. Without this, I fear that any recommendations made by the Inquiry will fall on deaf ears (as they have for the past 20+ years), lessons will not be learned, more mental health inpatients will die and we will be back in this situation in another 20 years.

It is blatantly apparent that at present there is an enormous disparity between physical health services and mental health services. It is clear to me as a layman, that this is both a cultural and systemic issue that needs to be addressed and I understand that the cultural aspect does not fall

within the remit of this Inquiry. To ensure that this Inquiry has not been a massive waste of time, money, work and trauma to the families involved, it must be ensured that recommended changes are acknowledged and acted upon. How can we be reassured that these changes have been maintained months, years and decades following this Inquiry? How can we ensure that the evidence to prove this is the case is complete, transparent and accurate? I cannot speak for anyone else, but I do not at present, have any faith that this can be achieved without the support and commitment of the Government to ensure that organisations such as The Trust cannot continue to manipulate and withhold information to protect its reputation as it has done for decades.

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

Signed:

[I/S]

Date: 06/06/2025