Witness Name: Lydia Fraser-Ward

Statement No. 1

Dated: 19 May 2025

THE LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF LYDIA FRASER-WARD

I, **Lydia Fraser Ward**, will say as follows…

Introduction

1. I am a Core Participant in the Lampard Inquiry ("**the Inquiry**").

2. This witness statement is to assist the Chair of the Inquiry with the matters set out in the request made by the Inquiry pursuant to Rule 9 of the Inquiry Rules 2006, dated 10 February 2025 (the "**Rule 9 Request**"), and with reference to the List of Issues published alongside its Terms of Reference. I have previously submitted to the Inquiry an Opening Statement and Commemorative Statement in September 2024, the contents of which I refer to as relevant in my response to the Rule 9 Request. I would ask that the Inquiry considers this statement in conjunction with those documents as part of my evidence.

3. The facts and matters contained in this witness statement are within my own knowledge. Where any information is not within my personal knowledge, I have identified the source of my information or the basis for my belief. The facts in this witness statement are true to the best of my knowledge and belief.

4. Given the passage of time, I have limited recollection of some topics covered by the Rule 9 Request. Where this is the case, and to the extent that I am assisted by any documents I have identified these to the Inquiry.

5. I was assisted in preparing this statement by Bates Wells and Braithwaite LLP, my recognised legal representative ("**RLR**") in the Inquiry.

Opening remarks

6. I am participating in the Inquiry's investigation because my sister, Pippa Whiteward (born Philippa Fraser-Ward), died in October 2016 while under the care and treatment (both inpatient and outpatient) of several hospital trusts after the birth of her second son in June 2016, the details of which I explain to the best of my knowledge from paragraph 30 of my statement.

7. Although my sister lived in Essex, the majority of her care took place outside of the county due to lack of beds in Mother and Baby Units ("**MBUs**") locally. It is my opinion that this distance from home, and an inappropriate early discharge from the Winchester MBU where she was receiving treatment in October 2016, significantly contributed to Pippa's death.

8. My statement necessarily focuses on Pippa's mental health struggles, but I would like the Inquiry to hold in mind that for much of Pippa's life she was well and did not require treatment. Her illness, post-natal depression, is sadly all too common.[1] Postpartum psychosis, the much more serious condition that Pippa also tackled, is much rarer, usually affecting 1 in 1000 women, however, as the NHS states: 'with treatment and the right support, most people with postpartum psychosis do make a full recovery'.[2] Although to her close friends, family and community, Pippa was an extraordinary person, the circumstances under which she found herself becoming unwell were perfectly ordinary and familiar to many – starting a family. I therefore ask the Inquiry to keep in mind that although some of the details that follow may appear to be specific to a patient with a rare mental health condition, it is one that could potentially affect anybody, and that can be recovered from if properly treated. Pippa's death was avoidable, it didn't have to happen. Due to lack of resources and numerous missed opportunities, her mental health was allowed to worsen to the point of no return, ending with Pippa's untimely death.

9. I would like to take this opportunity to also remind the Inquiry of all that Pippa offered. She was a much-loved member of her community in South Woodham

[1] The NHS estimate that 1 in 10 women will be affected by post-natal depression
[2] Postpartum psychosis - NHS.

Ferrers near Chelmsford in Essex, as well as being an active volunteer and local Parish Councillor. She loved to travel, made friends wherever she went and was always involved in groups and community activities where she lived and worked. She never appeared dull or depressed, making her a person that others naturally gravitated towards at social gatherings.

10. At the time of her death Pippa was only 36 years old. She left behind her husband, **[I/S]** and two sons who were just 5 years and 4 months old at the time of her death. Her suicide also affected her much larger family, including her mother, three sisters, brother and numerous other extended family members plus countless friends, who continue to miss her greatly. Even now, eight and a half years on from her death, many still feel the pain and sadness of her loss.

11. Although nothing can be done to restore Pippa's life or make up for the years of memories with her that we will never experience, it is my sincere hope that by sharing her story through this statement, questions which should have been asked of NHS staff and clinicians responsible for her treatment, and vitally regarding broader systemic issues, are now finally being raised. In addition, it is my most ardent wish that the promises made during the inquest into her death and the lessons that may, or sadly may not, have been learnt through that process are finally put into effect so that no other families have to lose loved ones in the manner in which Pippa's life tragically ended.

12. I will forever be grateful to have had the opportunity to participate in this Inquiry and share in this experience with the brave and courageous families who have come forward to share their loved ones' stories. I want to express my deepest and most sincere empathy with all those individuals who have been impacted by the issues under investigation by the Inquiry, with whom I stand in solidarity. It pains me to acknowledge that we may never know the true number of people who have been affected by the circumstances which are now under scrutiny. I hope that my statement will form part of the vital context to spur on those with the powers to investigate these tragedies to find answers to the many questions which remain.

Documents

13. As part of my preparation for the Inquiry I have discovered some documents at Pippa's home after her death, which included handwritten personal diaries and some medical notes. As well as my witness statement, I would like the Inquiry to accept as evidence the following documents.

    a. Opening Statement of Lydia Fraser-Ward (August 2024) "**Opening Statement"**

    b. Commemorative Statement of Lydia Fraser-Ward (August 2024) "**Commemorative Statement**"

    c. Commemorative Statement of Barbara Jane Wright, Pippa and Lydia's eldest sister (February 2025)

    d. Southern Health NHS Foundation Trust RCA Interview Notes Template with transcript from meeting on 28 November 2016 and family comments "**Southern Health Meeting Transcript"** (28 November 2016)

    e. Letter from HM Coroner for Essex to **Pippa's husband** with conclusion from Pippa's inquest ("**Coroner's letter**") (27 February 2017)

    f. Southern Health NHS Foundation Trust Investigation Report, commissioned into Pippa's death (Ref: 2016/28231) (Undated) (Author unknown) "**Southern Health Investigation Report"**

    g. Letter from Pippa's husband **[I/S]** 'My wife killed herself. We need more beds in Mother & Baby Units' addressed to Rt Honourable John Whittingdale OBE MP (3 August 2017).

    h. A poem written by Pippa 'Ode to Broomfield Hospital' about her treatment at Broomfield Hospital Emergency Department after being sectioned under the Mental Health Act, which we discovered after her death (Undated).

    i. North Essex Partnership University NHS Foundation Trust Care Programme Approach (CPA) Care Plan (17 June 2016) drawn up as part

of an assessment of Pippa's mental health treatment needs whilst on the Maternity Ward at Broomfield Hospital after the birth of her second son "**NEPT Care Plan**"

j. Letter from North Essex Partnership Trust ("**NEPT**") to **[I/S]** The Greenwood Surgery, South Woodham Ferrers regarding Access and Assessment Service (17 June 2016)

k. Initial Care Plans: Pippa (Undated) (Author unknown) (MBU unknown)

l. South Staffordshire and Shropshire Trust Healthcare NHS Foundation Trust – Olanzapine (Undated)

m. Pippa's Time Out Plan (Undated) (Author unknown)

n. Your Safety System: A User's Guide (Undated) (MBU unknown)

o. 'My experience of post-partum psychosis' Mind (Printed 13 September 2016)

p. 'Post partum psychosis' NHS Choices (Printed 13 September 2016)

q. 'Postpartum psychosis: severe mental illness after childbirth' Royal College of Psychiatrists (Printed 13 September 2016)

r. 'Postpartum psychiatric disorders' MGH Cener (sic) for Women's Mental Health (Printed 13 September 2016)

14. At this stage, the Inquiry has asked that I list the documents I would like to share in my witness statement by their identifying details, as above. If the Inquiry would like me to provide these documents, and to complete an Exhibit List in respect of the same, I would be happy to do so.

15. Due to the complexity of Pippa's treatment history, with my RLR I have prepared a detailed timeline drawn from the documents I exhibit, my own recollections, and that of family and friends. It has greatly assisted me in writing this statement, and I am producing it to the Inquiry as an aide memoire should it be of assistance ("**Pippa's Timeline**").

16. I would like the Inquiry to consider obtaining and reviewing all records pertaining to Pippa's care under Essex and non-Essex hospital and/or foundation trusts ("**trusts**") throughout the relevant period, including but not limited to:

    a. The Linden Centre (or other local mental health provider for Pippa's home treatment) 2011/ 2012 and in the years preceding 2016

    b. St Peter's Hospital, Maldon (January-June 2016)

    c. The Broomfield Hospital maternity ward (June 2016)

    d. The Broomfield Hospital Emergency Department (June – October 2016)

    e. The Stafford MBU including any investigation report into Pippa's death (August – October 2016)

    f. The Acute Mental Health Ward in Chelmsford (name unknown) where Pippa was admitted (6 October – 11 October 2016)

    g. The Winchester MBU (16 October – 27 October 2016)

17. At a minimum I would be grateful if the Inquiry seek to obtain the records relating to Pippa's admission on 23 or 24 June 2016 into acute care, given her family still do not know how many hospitals she was transferred between on that day (see further from paragraph 51), and her transfer from Winchester Hospital into the community on 27 October 2016.

Pippa's mental health history

18. I first became aware of Pippa's mental health difficulties when she was sixteen years old, in 1996. From childhood Pippa had high expectations of herself and, for whatever reason, she couldn't shake off this underlying pressure that she had to achieve and succeed, far beyond reasonable expectations, and if she didn't, then it meant that she was a failure. For example, whilst revising for her mock GCSE exams, Pippa was under immense stress and became extremely anxious. Although I never saw it for myself, our mother ("**Mum**") recalls Pippa shaking uncontrollably all over when she realised that she had forgotten to revise for one of her exams. She was terrified of failure and struggling to cope

with the pressure of expectation from her academic work and the impact it could have on her future.

19. On her sixteenth birthday, on 10 January 1996, Pippa took [I/S] paracetamols in what appeared to be an attempt take her own life. After that incident, she dropped out of school for the remainder of that academic year and the next. After approximately 19 months at home, which she spent mostly reading and writing poetry, Pippa enrolled at SEEVIC (South East Essex VI College - now USP College) in Benfleet, at the same time as me. I will never know for sure if her taking the paracetamol was a genuine suicide attempt, or a cry for help, but in either case it was always my view that Pippa was seeking support to cope with a stressful time. I think that a mental health assessment for anxiety could have really helped her at that time, but as far as I am aware, she never received any kind of assessment, or diagnosis, and was not taking any medication. I have seen from the NEPT Care Plan, found recently in preparation for this Inquiry, that Pippa reported experiencing two periods of depression before the age of 20. I was not aware of this before seeing this document. This is not because I did not know my sister well, or did not spend time with her. We were very close and enjoyed each other's company often, but Pippa was excellent at masking her true feelings and often concealed any signs of stress or anxiety that she experienced.

20. Pippa did not have any further significant mental health difficulties that I am aware of until she had her first baby on 24 July 2011, aged 31. After the birth she became quite unwell, displaying an unusual level of emotional distance and coolness for several months afterwards. Her behaviour and responses became unpredictable, and her personality appeared to transform. Our Mum stayed with her and her husband, **[I/S]**, at their home to help support them. Although I did not witness it for myself, our Mum noticed her displaying periods of what appeared to be mania, although it was subtle and not obvious unless you knew Pippa well.

21. While Pippa's high expectations of herself had motivated her throughout her life to continually challenge herself and try new things, when she became unwell after the birth of her first child, it became a catalyst which would fuel a downward

spiral of self-loathing. I remember during that time, there was one incident when Pippa took her baby out for a walk in his pram. Just before she left, she said to our Mum "I am so sorry to do this". She was then absent for several hours and our Mum became seriously concerned that Pippa had gone out to harm herself; even though she had never mentioned an intent to do so, Mum could tell that she was not herself. She became so concerned, that she went out to look for Pippa around town, who eventually returned home a few hours later. I recall speaking to Mum on the phone shortly after the incident and asked her why Pippa had left the house with the baby unsupervised.

22. Although it was not outwardly obvious that Pippa was ill, we could sense that something wasn't right and we were concerned for her safety. However, it was difficult to raise the subject, because her illness related so closely to her experience of motherhood. It's a time in life when many women feel under an intense period of scrutiny, where they are being judged about every decision they take. Pippa was already particularly sensitive to issues around failure and 'not being good enough', so to suggest that she might be struggling or experiencing any kind of mental health illness felt as though it could trigger or worsen any post-natal depression she may already be experiencing. I recall feeling cautious around her after the birth of her first son, as if treading on eggshells all the time, for fear of upsetting her, or making a comment that she could interpret as judgement or criticism. The nature of Pippa's illness made communication with loved ones very challenging, and in turn it felt difficult to support her; I found myself communicating via our Mum, rather than to Pippa directly, because I didn't want her to feel obliged or overwhelmed by unexpected, or unwanted, visitors.

23. Such was her ability to conceal her true emotions, I only now know that Pippa received a diagnosis of bipolar disorder in 2011. She lived with this for 5 years having never disclosed it to me, and I only found out as part of the inquest into Pippa's death in 2017. The Southern Health Investigation Report commissioned into Pippa's death states that Pippa was diagnosed with bi-polar disorder in 2013, however this is incorrect. The NEPT Care Plan confirms that Pippa was actually diagnosed with bipolar disorder in 2011, although does not

specify when or where this diagnosis occurred. I can only assume that Pippa must have had a mental health assessment to receive that diagnosis, and that it was probably following the birth of her first son, although I cannot be certain.

24. To this day, I have never seen any records confirming Pippa's bipolar disorder diagnosis, or which clinician and hospital trust made it.

25. Pippa's personal diary from 2012, the year after her first baby was born, describes feeling emotionally low. She has diarised a postnatal depression session in March 2012, and later that month noted that she attended Cognitive Behaviour Therapy ("**CBT**"). Pippa's best friend has since informed me that she recalls Pippa confiding in her that she had been on a waiting list for CBT for a long time that year. It is likely that preventative measures could have made a difference earlier, and long waits for therapy increase the likelihood of serious problems further down the line, which in Pippa's case became a reality.

26. I did not know after Pippa's first baby was born that she had been feeling that low, or that she was prescribed Sertraline, an anti-depressant, between 2011 and 2014. I am aware of this now from her diaries and the Southern Health Investigation Report.

27. Our Mum has told me that after the birth of Pippa's first baby, she started driving her to group therapy sessions in Maldon, Essex, although she cannot recall the dates or exact location of those sessions. I do not know whether Pippa was on any medication at that time to treat her bipolar disorder, or if therapy was something she was offered following a mental health assessment. I also do not know how long she attended the sessions for, or what took place at them. We know from the NEPT Care Plan that Pippa was known to Essex community mental health services and was seen by the Home Treatment Team after the birth of her first baby, following a period of mania. However, there is no mention of her treatment in Essex in 2011, or at any other time before 2016, in the Southern Health Investigation Report.

28. By April 2012 Pippa describes in her diary feeling more hopeful, looking forward to future plans and having fewer suicidal thoughts.

29. I distinctly remember in December 2015 when Pippa announced that she was pregnant with her second child, although I was thrilled for their family, I was deeply concerned that she might become unwell again, recalling the difficulties she had faced when her first son was born. Had I known she had received a diagnosis of bipolar disorder at that time, I would have attempted to talk with her directly about her feelings during her pregnancy.

Pippa's mental health after the birth of her second child

Broomfield Hospital Maternity Ward *– 10 June 2016 to 17 June 2016*

30. Pippa's second baby was born, prematurely at 34 weeks on 10 June 2016 in Broomfield Hospital. It is my understanding that she had been planning to have the baby at St Peter's Hospital in Maldon[3] but due to the unexpected early birth she was admitted to Broomfield. Our Mum recalls Pippa saying that her medical notes had not been transferred when she went into labour, so it appears unlikely they were aware of her previous mental health history or any planning that may or may not have been done throughout her pregnancy.

31. On 12 June 2016, I went to visit Pippa on the maternity ward at Broomfield Hospital.[4] She was staying in a private room and I do not recall seeing any clinicians or nurses attending to her or taking observations during my visit, which lasted approximately 2 hours. She appeared quite isolated in her room. I recall Pippa wearing pressure stockings and walking very slowly out to meet me and my husband in the visitor area, and she stated that she was in a fair degree of physical pain from the stitches and surgery. No staff offered to assist her.

32. Pippa's new baby was in a mobile incubator unit in another part of the hospital ward receiving light therapy. I don't know why the baby was being kept in a separate area from Pippa, or who took the decision for the baby to be in a

[3] Today, St Peter's Hospital offers the 'Together with Baby (Essex Parent Infant Mental Health Service)', a specialist provision of individualised treatment plans for expectant and new mothers who have difficulty bonding with their babies; however this only began in May 2019 and would not have been available to Pippa when she was pregnant in 2015-2016.
[4] At the time Broomfield Hospital fell under the North Essex Partnership Trust ("**NEPT**"), which merged and became EPUT in April 2017.

different room from her, as I had seen other mothers with their babies together in the ward.

33. I could tell immediately that Pippa was emotionally unwell. Although she appeared upbeat, as her sister I could tell it was a thin veneer and she appeared unusually frustrated and tired. I recall attempting to make jokes to help her laugh, and feeling that I was an irritant rather than a remedy. She did not want to receive help or use a wheelchair even though she was clearly in pain when she walked. I now know, having read her Care Plan and diaries, that Pippa was struggling to sleep due to high levels of noise on the maternity ward, which was causing her anxiety and stress. During her week at Broomfield Hospital she reported to clinicians that she hadn't slept for seven days due to "alarms beeping", "babies crying", "ticking clocks" and the helipad above her room. By 16 June 2016 Pippa reached out for help from staff and requested a mental health assessment and referral, which was when her NEPT Care Plan was drawn up.

34. The NEPT Care Plan states that after Pippa gave birth to her first son in 2011 she experienced a period of mania and made plans to end her life. This is the first record I have encountered which directly states Pippa was suicidal in 2011. It goes on to outline the levels of sleep deprivation Pippa was experiencing at Broomfield Hospital in 2016. You would expect this would raise concerns about her risk of suffering from psychosis increasing; sleeplessness is a well-documented trigger of post-partum psychosis, particularly for patients with bipolar disorder.[5] In spite of this, and her recorded history, the NEPT Care Plan goes on to state "I do not feel that she [Pippa] will need long term support and may be discharged in a week or two", and appears oblivious to the severity of her illness. It is evident from Pippa's subsequent deterioration when she was sent home that this was not the right treatment option for her.

35. Much of the rest of the NEPT Care Plan contains boiler plate wording. This is in contrast to the requirements in paragraph 12 of the NEPT CPA and Non-CPA Policy and Procedure [2015][6], the version in place at the relevant time,

[5] Sleep and Postpartum Psychosis: A Narrative Review of the Existing Literature - PMC.
[6] See MK-020 of *Assessments and Routes to Admission*, Exhibits Bundle.

which states that contingency plans should include tailored arrangements to prevent a crisis developing including "contact details, early warning signs, relapse indicators and key triggers". It records Pippa as providing 'No response' to all the questions relating to her mental wellbeing, so it is difficult to know how she was feeling at the time it was written. It recommends that Pippa be sent home to try and gain some sleep, leaving her baby behind at the neonatal ward at Broomfield Hospital. There is no apparent consideration for how separation from her newborn baby might affect her state of emotional or mental health. In her diary, Pippa writes a pros and cons list for leaving Broomfield Hospital at the time, outlining the benefits of (potentially) gaining more sleep, even though she also had a five year-old child to care for her at home, versus missing her newborn child. She writes: "How will I cope emotionally knowing I have left him - will I feel like I have abandoned him?" and goes on to question whether the decision will "trigger post-natal depression?". Nonetheless, the Care Plan recommended she be discharged under the care of the Crisis Home Treatment team for monitoring, although no details are provided of how this follow-up would take place[7]. It states that she was offered sleeping tablets, but declined the medication as she was concerned as to how it would affect the baby since she was breastfeeding at the time. It also recorded that Pippa would be seen by the team psychiatrist "at the earliest possibility", and that she and her husband would be provided with Mental Health support phone numbers.

36. I have found a further document entitled 'Initial Care Plans: Pippa' which is a treatment plan identifying her needs and goals, to promote her recovery whilst on an MBU. This document is undated, unsigned and it is unclear which hospital trust provided it to her. It refers to a Care Plan Approach, which reflects the terminology of the NEPT Care Plan; however, it is not tailored, except to say that Pippa would be placed on "5-minute observations" due to "feeling very low in mood and wishing to die". It also notes that there should be a Crisis and Contingency plan completed before leaving the Trust's care. However, there was also no Crisis Plan recorded at all in the relevant section of the NEPT Care Plan, nor was it signed by Pippa. If she refused to sign, this should have been

[7] Contrary to requirements in paragraph 17.5 of the NEPT CPA and Non-CPA Policy and Procedure [2015], see MK-020 of *Assessments and Routes to Admission*, Exhibits Bundle.

recorded[8]. She had not written any comments to indicate whether she agreed with being discharged. Crisis plans are intended to set out the action to be taken if the service user becomes ill or their mental health deteriorates rapidly, using risk assessments and previous experience of what works for that individual. The lack of one in Pippa's notes is in direct contravention of paragraph 9.2 - 9.5 of the NEPT CPA and Non-CPA Policy and Procedure [2015][9].

37. The headlines of the plan were also copied to Pippa's GP, [I/S] [I/S]

***Discharge to the community** – 17 June 2016 to 23 June 2016*

38. Pippa was discharged home a week after giving birth on 17 June 2016. In the days following she kept a sleep diary, with the first night alone spanning 14 pages of handwritten notes reflecting her manic state. These were made only hours after being discharged from Broomfield's Maternity Ward, which suggests she was likely already in a manic state when being assessed for discharge.

39. In her sleep diary she calculates achieving between only 2-3 hours of sleep per day. Her sleeplessness therefore did not improve when she was discharged, increasing the risks associated with prolonged insomnia for a patient with bipolar disorder, which were not considered in the Initial Care Plan or NEPT Care Plan.

40. To my knowledge, the only psychiatric assessment Pippa received on leaving Broomfield Hospital was during a home visit by two members of the community mental health team, named [I/S] who she did not know and assumed were locums. She made a handwritten note of their visit in her calendar diary, but there is no reference to their visit or assessment in any medical notes.

41. Clearly, sending Pippa home and separating her from her baby did nothing to support her recovery. Within 6 days of being discharged from Broomfield

[8] Paragraph 9.5 NEPT CPA and Non-CPA Policy and Procedure [2015] MK-020 of *Assessments and Routes to Admission*, Exhibits Bundle.
[9] See MK-020 of *Assessments and Routes to Admission*, Exhibits Bundle.

Hospital as a maternity patient, Pippa was in crisis (see further from paragraph 42 below).

Broomfield Hospital Emergency Department *– 23 June 2016*

42. On 22 June 2016, Pippa's husband [I/S] contacted me on Facebook to cancel plans that he had made to celebrate his birthday [I/S] saying that it would be too much to organise considering Pippa's recent discharge from hospital on 17 June 2016. Very late that night, around midnight, Pippa's husband phoned me; his voice was anxious as he explained that he had called an ambulance for Pippa. He went on to tell me that she had been hearing voices through the walls and that he wasn't sure what to do to help her. He felt conflicted as he didn't want to send Pippa away, but was afraid for her wellbeing and I reassured him that he had done the right thing. We both believed that she was going to be in the right environment to get better and that she would receive the specialist support that she needed.

43. Days later, I found out that the ambulance first took Pippa to Broomfield Hospital's Emergency Department. Although she never told me herself about her experiences there, I discovered after her death that her short stay was incredibly traumatic. In an open letter entitled "My wife killed herself" that Pippa's husband sent to his local MP Sir John Whittingdale about a year after Pippa died, he begged for more funding for specialist care and beds in MBU units in Essex. He describes Pippa being refused by a MBU when she arrived at Broomfield Hospital, and instead was forced to remain sedated and strapped to a bed in the nearby Linden Centre as if in "an NHS version of a holding cell".

44. Our Mum also recalls Pippa had contact with a police officer whilst at the Emergency Department. She asked him: "Where's my baby?" and he replied "Baby? There's no baby" which I can imagine caused her a lot of distress about the whereabouts of her young child, while already experiencing psychosis and auditory hallucinations.

45. I know very little more about Pippa's stay in Broomfield Emergency Department, To my knowledge neither her husband nor any of Pippa's family members have seen any records about her stay here, nor is there any mention of it in the Southern

Health Investigation Report. I am not aware of Pippa having contact with any specialist psychiatric liaison or nurse during her time there, which may have had a detrimental effect on how she was treated by clinicians and staff.

46. Although Pippa didn't feel able to share with me what happened to her at Broomfield Emergency Department, during my last visit with her at her home in early October 2016 she told me that she had "lost her phone" whilst she was at the Emergency Department. She therefore had no contact phone numbers for any of her immediate family or friends, and had been writing them down in a notebook as and when she had been able to see people face to face. I was shocked to discover this, and couldn't believe that for the previous two months, she had no way of contacting me. Even now, years later, I find it incredible to think that whilst Pippa was vulnerable and in crisis, her personal items were taken away from her and she had no way of communicating with family or friends for help.

47. After Pippa died, my mother found a poem Pippa had typed on her laptop describing her stay at Broomfield Hospital's Emergency Department.

48. Although her stay was not much more than a day, this poem demonstrates that she must have been extremely frightened and traumatised by the treatment she received in that department.

'Ode to Broomfield Hospital

How I wish to see you burn
Never to rise again
To darken all my hours,
And terrify strangers in danger
And frustrate my friends
And endanger myself
And those I hold closest.

When will you burn?

Today, tomorrow or soon or never?

Will you continue to terrorise and terrify?

Or does everyone abandoned within your walls
Need to learn to survive

And rise like the phoenix
From the ashes of your disgrace.

Shame,
Shame,
Shame.'

49. I find it deeply upsetting reading this back after Pippa's death. I wish I knew exactly what happened to her, but without notes or records to refer to I can only imagine the worst. I have serious doubts about whether Pippa was treated with respect and dignity by clinicians and hospital staff during her crisis.

Transfers and admission to Staffordshire Mother and Baby Unit *– 23 June 2016 to 25 July 2016*

50. To my knowledge, Pippa was subsequently transferred from Broomfield Emergency Department several hundred miles away to an MBU under the Staffordshire and Shropshire Healthcare NHS Foundation Trust on either 23 or 24 June 2016. The reason there is some uncertainty about the admission date is because both her husband's letter to his MP and Pippa's diary at the time list her admission on 24 June; however, Southern Health's Investigation Report claims she was admitted on 23 June. It is my belief that this, along with many other statements made in that report, is erroneous.

51. Her husband has told me that when Pippa arrived at Broomfield Emergency Department, there were no beds available in the local Rainbow Ward MBU. The hospital enquired at other MBUs, but there was only one other bed available in the whole country, and the relevant MBU (which he believed to be in London) rejected Pippa's admission. The Southern Health Investigation Report confirms this, although it does not state where or why she was not accepted. In evidence produced to the Inquiry by EPUT (see Exhibit AG2-001 'Out of Areas Beds List – Wards and Services ("**AG2-001**"), rows 196 - 198[10]), there is anonymised data regarding a patient who was "taken to Margaret Oats MBU but declined on arrival and sent back" on 21 June 2016. This unit is in Nottingham. It then records "Patient admitted to Brockington following decline from Margaret Oats

[10] This document is very difficult to decipher and I would be grateful for confirmation from the Inquiry whether Alexandra Green will be called for oral evidence to provide its context and explain how it should be read.

MBU - contact from Brockington MBU on 25/06/2016 but not clear if this was the date of admission". Brockington is an 8-bed MBU in St George's Hospital in Staffordshire and matches references in Pippa's diary from that time. Finally, row 198 states: "Patient appears to have transferred from Brockington to Winchester - contact from Winchester MBU on 25/10/2016 but inclear [sic] if this was the exact admission date".

52. While the dates listed are inaccurate (AG2-001 acknowledges that they are not necessarily the dates of admission), I believe these records may refer to Pippa's transfer from Broomfield Emergency Department to subsequent wards across the country. This new information suggests that, during Pippa's crisis, she may have been transferred approximately 3 hours to the East Midlands, only to be rejected upon arrival before then being transferred to Staffordshire. Her husband has no knowledge that this happened, and was under the impression Pippa had been transferred (and subsequently rejected) from a unit in London before ending up in Staffordshire. The ongoing lack of clarity about what happened to Pippa once she was collected by ambulance is incredibly worrying. Either the records of patient data is inaccurate, or there was additional transfer information which was never shared with her next of kin. In either case, this shows a poor degree of record keeping, and communication with family members. If the data is correct and does indeed relate to my sister, it remains possible that she was physically restrained (without her phone) throughout this unnecessary journey, and it horrifies me to think how frightened she could have been during that time.

53. I have never seen any medical records relating to Pippa's stay in Staffordshire; any notes Southern Health may have been provided with during their investigation were not shared with her family or during the inquest proceedings into her death. The Southern Health Investigation Report records that Pippa was subsequently diagnosed with Puerperal Psychosis at the Staffordshire MBU and sectioned under the Mental Health Act 1983. As I have no records for any treatment she received at either Broomfield Hospital, Brockington MBU or her transfers in between, I cannot know what mental health assessments Pippa received at this time, or what treatment, if any, she was prescribed. This

demonstrates how communication between trusts and the sharing of medical records with her family was managed inadequately for the duration of Pippa's treatment, as well as after her death.

54. During Pippa's treatment at the MBU in Staffordshire, she showed several peaks and troughs in her recovery. Due to lack of engagement from clinical staff (see further from paragraph 147 below) I was unable to visit Pippa whilst she was there, so I cannot comment greatly on the ward environment or how it affected her.

55. However, I recently discovered some of Pippa's diaries including one which has dated entries from June to August in 2016 covering her stay at Staffordshire MBU. In them she includes many personal reflections, including some about her treatment. Much of her writing appears manic. It must have been a very frightening time for her, particularly with a newborn baby to look after as well. It is my view that the distance of the ward from her home contributed significantly to the delay in her recovery, as she expresses feeling homesick and clearly missed her husband and eldest son very much.

56. Some of Pippa's diary entries from July 2016 refer to an advocate called [I/S] [I/S] who appears to have had some level of oversight over Pippa's care there. I do not know if she was an Independent Mental Health Advocate (who I understand provide support patients lacking capacity) or held some other role. In her diary Pippa records feeling very grateful for this individual, who attended MDT meetings to help advocate for her and who she felt understood her needs and was 'on her side'. This is an example of how there can be an effective and coordinated approach to care. I have never seen reference to an advocate in any of Pippa's later treatment.

57. In one notable entry towards the back of her diary near the time of her discharge, Pippa expresses a wish to nominate the Staffordshire MBU and its staff for an award. On the opposite page, Pippa made a list of books and pamphlets that she wanted to write when she returned home, including an idea for a book on her personal experience of postpartum psychosis. She writes: '"How to survive the NHS – brutal autobiography with accounts from service

users focused on mental health and Broomfield vs. Brockington". This entry is reflective of the varied quality of care she received in each hospital. Although we can never know now what she would have written, it feels exceptionally important to note that her experiences were vastly different under different trusts, so much so that she felt compelled to publish a book about them.

58. By late July, Pippa's annual diary describes days of leave from the MBU with her husband and her children and going out on the hospital grounds. Her writing appears lucid, and from August onwards mostly records social gatherings, children's birthdays and plans to go home and rejoin community societies that she had previously been involved with.

59. I do not know the exact date Pippa was discharged from the Staffordshire MBU to the Essex Community Mental Health Team, as I hold no records relating to her stay in that unit. Her diary suggests that she was first allowed home on 25 July and returned for a review on 2 August; it is unclear on which date she was fully discharged. Although I would expect a gradual transition with support from both the MBU and the Home Treatment Teams in collaboration, I have not seen any notes or records to suggest that Pippa received any support once she was back in the community.

60. Amongst Pippa's medical notes I have found a document from the South Staffordshire and Shropshire Healthcare NHS Foundation Trust with information about Olanzepine, which is a medication used to treat symptoms of psychosis, bipolar mania and crisis. Pippa's handwriting on the document states "Yellow Pills" and she has circled the word "psychosis" and the fact that treatment with Olanzepine can "stop these symptoms coming back". She has also circled "dry mouth" as a common side effect. I presume this means that Pippa was prescribed this medication when she was discharged home from Stafford MBU in August 2016, although the document itself is undated.

***Discharge to the community** – August 2016 to 6 October 2016*

61. After Pippa was discharged from the Staffordshire MBU, she came to visit me at my home on Sunday 21 August. I recall feeling nervous about her visit because I was worried that I might say or do something that would upset her

which could potentially make her feel worse. I did not know whether to acknowledge that she had been unwell, and she did not mention her illness or treatment during the visit. Instead, Pippa spent much of the time quietly standing in the garden with me. Her demeanour was neutral and flat; she seemed a distant version of herself as though she was on pause.

62. Shortly after Pippa's discharge, I learnt of an incident at home where our Mum walked into the kitchen and found Pippa holding a carving knife. Mum later told me that she was worried Pippa might try to hurt herself with it. She took the knife away but Pippa picked it up again forcing Mum to physically prise it away from her.

63. There were several incidents of a similar nature during the end of that summer. I was due to see Pippa again on 10 October 2016, after she asked me to clear my work schedule that day to visit her at her home. However, a couple of days before, she sent me a text message to cancel, saying she had a hospital appointment.

Admission to Chelmsford Acute Mental Health Ward *– 6 October 2016 to 11 October 2016*

64. Although I had no idea of this at the time, the Southern Health Investigation Report records that Pippa was informally admitted to an acute mental health ward in Chelmsford (under the care of NEPT) between 6 October and 11 October 2016, and so she must have been messaging me from hospital to cancel our plans.

65. To my knowledge our family holds no notes or medical records for that stay. The Southern Health Investigation Report gives very little information about it, failing to even state which mental health centre was providing her care, let alone the reasons Pippa asked to be admitted, or on what basis she was considered safe for discharge. The risk assessment leading to the decision to discharge Pippa, if it took place, was evidently insufficient given Pippa was readmitted after less than a week (see further from paragraph 67).

66. The Southern Health Investigation Report also states that Pippa was discharged to the community mental health team following this admission, however there are no references to any support of this nature actually being provided during October 2016. Evidently, any support she received from NEPT, either as an inpatient or in the community, was utterly worthless, as her mental health rapidly spiralled downwards and she made several attempts to take her life in the following days.

Incidents in the community *– 11 October 2016 to 16 October 2016*

67. The last time I saw Pippa alive was when I went to visit her at her home on 13 October 2016. Although I didn't know it at the time, this was just two days after she had left the Chelmsford Acute Mental Health ward. She appeared noticeably unwell and agitated, thinly veiling her anxiety with a positive tone of voice. When I held her baby, she would look at me and smile, before going into the kitchen where I could hear her crying and repeatedly saying to her husband "don't want to be here". At the time I thought she was telling him that she didn't want *me* to be there and I felt very conflicted about whether I should stay and continue to try and help look after the children and make meals, or if the presence of relatives was making her feel worse. I considered leaving, but Pippa would then come back into the living room speaking brightly, making conversation with me and acting as though she was feeling fine.

68. On that day, we walked to Pippa's son's school together, just the two of us, to collect him. I wanted to ask her then about her treatment, but was anxious about triggering her. So, we talked about how she was feeling generally, and she appeared agitated and concerned about being late. She said she missed her dog, who she had given up for adoption earlier in the year, but beyond that, she found it difficult to open up to me. Upon arriving at the school, she went over and spoke to many of the parents waiting there, and it was clear that she was well known and liked amongst her son's school community.

69. Later, upon returning home, Pippa looked distressed when the baby began crying. I asked her: "Don't you want to hold him?" and she looked at me, almost frightened, as if she was afraid of hurting him. I reassured her that she knew

what to do and that she was a good mother but, in the end, she asked our mother to hold him and Mum ended up caring for the baby most of that afternoon.

70. Throughout the day Pippa's reactions were unpredictable and often highly charged with emotion. It was difficult because none of her immediate family, apart from her husband, had spoken to or had contact with any clinicians regarding her care, and we had no advice or support on how best to address her feelings or discuss her anxieties. If I had known what support should have been available to her, I could have contacted NEPT to inform them of her worrying behaviour and asked for help.

71. When it was time for me to leave, her husband kindly offered to drive me down to South Woodham Ferrers train station. Unusually, Pippa insisted on coming with us for the short ride. At the station, she got out of the car and gave me a deep, long hug. She then insisted that I come back for another visit on 28 October; I was supposed to be working on that date, but she clearly wanted me to come then, almost begging me to clear my work schedule. I told her I would do my very best to get the time off work so I could be with her on that date, which didn't seem to have any particular significance to me at the time.

72. In the end, I never changed my work plans, as when they returned home from dropping me off at the station Pippa attempted to take an overdose of paracetamol (to which she is allergic). The Southern Health Investigation Report confirms that Pippa took **a number of tablets and was planning to take to take** more with the intent of ending her life, before being discovered and stopped by her husband With hindsight, it is very upsetting to know that Pippa had given me that huge hug knowing that she intended to die as soon as she got home. The date she had asked me to clear for a return visit, 28 October 2016, turned out to be the day before she died.

73. To my knowledge, no further action or support was provided by NEPT after Pippa's overdose attempt, however, just two days later, on 15 October 2016, the Southern Health Investigation Report records Pippa attending the Broomfield Emergency Department having "deliberately cut her wrists", and

agreeing to an informal admission to an MBU in Winchester as, once again, there were no beds available in Essex.

74. The Southern Health Investigation Report records the multiple attempts Pippa made to harm herself in the summer of 2016. Despite her frequent requests for a referral to acute mental health teams, as early as June, Pippa was continually discharged back to the Home Treatment team whilst her mental health deteriorated. She was finally admitted as an inpatient with her baby, to Winchester MBU, 120 miles away from home on 16 October. She died less than two weeks later.

***Admission to Winchester Mother and Baby Unit** – 16 October – 27 October 2016*

75. On 17 October 2016, the day after she was admitted to Winchester MBU,[11] Pippa requested again to be moved to an Acute Ward as she felt unable to look after her baby and was anxious in her new environment. Instead, she was told she would remain on the ward and could speak to the Consultant Psychiatrist the following day.

76. When Pippa spoke with the Consultant Psychiatrist on 18 October 2016, records show that she reported feeling in "low mood for about a month and would like to be dead, as she couldn't see herself getting better and stated she couldn't take any more". Pippa expressed doubts about being able to look after her baby and continued feeling anxious about caring for him. She self-reported that she had mania for around six weeks whilst an inpatient at Staffordshire MBU, and that whilst she felt well when initially discharged, she quickly deteriorated upon returning home. She also confirmed to the Psychiatrist that she had been mentally unwell after the birth of her first child, firstly with an episode of mania, followed by a number of months of low mood. During this discussion, Pippa repeated her request to be referred to an Acute Ward, but was denied. The Psychiatrist instead told her that she should remain in the MBU and they would review again in a week.

[11] Under the Southern Health NHS Foundation Trust.

77. The Southern Health Investigation Report also notes that Pippa was desperately missing her family, asking to be admitted to a MBU closer to her home. This led to the Winchester MBU contacting Chelmsford MBU to request a bed. At that time, the unit was full, so Pippa was added to a waiting list, but they reported that there were already four other women waiting for beds ahead of her. Had her treatment been closer to home there would have been more opportunities for her family to visit, and at shorter notice; her husband's presence often calmed Pippa's anxiety and enabled her to cope with inpatient treatment much better.

78. Whilst Pippa was at Winchester MBU, the Southern Health Investigation Report records that a care plan was drawn up to provide her with some respite. I have found amongst her documents a simplistic timetable entitled 'Pippa's Time Out Plan'; it is undated and does not have the name of a hospital trust on it, but I can only assume this is the care plan in question. It schedules short periods of 2-3 hours when staff would care for the baby whilst she had bursts of protected time to sleep.

79. What I know of Pippa's treatment at Winchester MBU is largely from the Southern Health Investigation Report records timeline, as I was not able to visit her while she was on that ward. In the early days of her admission, Pippa was sufficiently high risk to be on 5-minute observations, although these were later reduced to general observations. The Investigation Report records that on 19 October 2016 Pippa expressed suicidal thoughts and plans of how she would kill herself. On the same date, she was found to have tied her dressing gown belt around her neck "loosely". Observations were subsequently increased to 1:1 for Pippa and her baby, with observations every 15 minutes overnight. This became the first of two occasions that Pippa considered using her dressing gown cord as a ligature whilst on the Winchester MBU. During another assessment on 19 October, Pippa described feeling low in mood, objectively flat and still having suicidal thoughts, but after a visit from her husband reported that these were not as strong as in the morning. She denied plans to harm herself and reported feeling able to keep herself safe whilst out with her partner. Pippa

and her husband therefore had a brief period of leave where she stated she felt much more relaxed and less anxious.

80. The following day, 20 October 2016, Pippa was observed presenting in a brighter mood and taking care of her baby. However, she asked again to be moved to an acute ward. Her request was denied. She also requested to speak with a doctor, but there's no records confirming whether this ever happened.

81. On 21 October 2016, a nurse from Winchester MBU called Pippa's husband **[I/S]** to inform him that she had expressed a wish to accompany him to the baby's immunisation appointment on 24 October, requiring overnight leave. Plans began to be made for Pippa to leave Winchester MBU on 24 October for temporary leave. The following day, on 22 October, her husband visited Pippa on the ward and she was permitted leave to go into Winchester town centre with him and the baby for the afternoon. Plans for temporary leave on 24 October were then confirmed.

82. On 23 October 2016, Pippa was reported as "appearing stable", taking part in activities on the ward and caring for the baby in the evening. She was allowed escorted leave from the ward to go to a nearby Costa Coffee café.

83. On 24 October 2016 her mental state rapidly declined when Pippa was informed by staff that her home leave had to be postponed as the baby's immunisation appointment had been moved a few days later. She quickly became very upset and homesick as a result of this. That evening she asked staff for paracetamol for congestion and cold symptoms. She attempted to convince clinicians that her allergy no longer affected her, even though she had attempted to take an overdose of the same medication at home only 10 days prior. Following this incident, the nurse requested a call from the Duty Doctor but they never called back. Plans were made by staff to follow up with doctors in the morning.

84. The following morning, on 25 October 2016, against the advice of relatives, I decided to phone Pippa on the ward. I had never been provided with contact numbers, so I researched contact details for the hospital online and asked to be transferred to a number of different wards until I could locate her. Pippa

sounded flat and distant on the phone, quite unlike her typical self. In my usual way, I attempted to make her laugh, or cheer her up, but she was detached from everything I said, sounding emotionless. I said to her: "I have no idea what you're going through, but if today is bad, tomorrow will be a better day." I reminded her that she was "needed", numerous times, and implored her to remember how much she was loved by her family. I also informed her that I had news to share with her, but that I would tell her next time I would see her in person, in the vain hope that this would encourage her to keep going. When the call ended, I put the phone down and had a terrible feeling that I might never speak to her again. Sadly, that instinct turned out to be true, as that was the last conversation we ever had.

85. Later that day in the afternoon, there was a multi-disciplinary team review with Pippa where she reported that although her confidence had improved, she still had anxiety about looking after the baby and that she couldn't cope with being a mum or with life.

86. Following this, either on the same day (25 October) or the following day, Pippa attended a group therapy session focused on dealing with anxiety and stress. The session triggered a number of anxieties for Pippa and she requested a 1:1 session with the Psychiatrist immediately afterwards where she expressed feeling low. She stated that feelings of inadequacy had been brought to the surface during the session and our Mum recalls how Pippa's mood changed drastically after attending that group. It unearthed repressed emotions which caused Pippa to feel like a failure and bad mother; she reported to her best friend during a phone call from the ward after the session that she did not feel that she could trust the validity of some of her memories. She did not know what was real or not, which was causing her immense distress. There was no support in place to help Pippa unpack that trauma, nor was she provided with tools to help her to deal with these new feelings when she was already in a vulnerable, depressed and suicidal state of mind. Even though she described these anxieties in this joint meeting with both the Ward Psychiatrist and Consultant Psychiatrist, no further action was taken. As far as the Southern Health

Investigation Report shows, she remained on reduced general observations and was considered no longer suicidal.

87. During the day on 26 October 2016, Pippa was observed approaching the unit office in tears. She handed in her dressing gown cord, the same one observed tied around her neck a few days earlier, and asked staff to take it away from her; she reported that she had once again attempted to end her life using it as a ligature from a fixed point in her room. Red marks were clearly visible on her neck from the attempts she made to do this which had been unobserved by staff. The Southern Health Investigation subsequently found that no one made any record of this incident on Pippa's medical notes on the Ulysses safeguarding system - in breach of the SH NCP 17 Policy for Reporting and Managing Incidents[12] - until after she died, when they were added retrospectively.

88. Following this incident, observations were that Pippa's vital signs were all within normal range, but in a 1:1 meeting with the nurse she described the feeling of strangulation during her attempt. She expressed in detail her feelings of isolation, how she hadn't made friends on the ward and how she rarely got to see her family. She stated that she felt scared about leaving the hospital and was worried about being at home with a 5-year-old and baby. She was frightened that she would never be able to recover and expressed a general sense of hopelessness. When asked if she could keep herself safe on leave, she stated "I think so" but confessed that she was unsure whether she was ready to go home.

89. A crisis and contingency plan was drawn up to increase observations to every 15 minutes after the incident and Pippa was encouraged to attend the craft session on the ward later that day which it was felt might help reduce her feelings of anxiety. She was also advised to inform staff if she felt suicidal.

90. The duty doctor called Pippa's husband on 26 October to tell him about Pippa's act of self-harm. Despite this suicide attempt and the anxieties she reported, the doctor

[12] Referred to at page 6 of the Southern Health Investigation Report.

only suggested postponing her overnight leave (scheduled for that evening) until the following day, with a view to her still going home.

91. The evening of 26 October, the same day as her ligature attempt, Pippa was observed vomiting. Although she was seen making multiple trips to the toilet, she denied being unwell. A staff member from the unit was off sick with a diarrhoea and vomiting bug and it was assumed Pippa had contracted the same illness. She was asked to remain in her room to prevent further infection on the rest of the ward. That night, her husband collected the baby for his immunisation appointment the next day and Pippa remained on the ward without him, in isolation.

92. On 27 October 2016, a bed became available in Chelmsford MBU, but Winchester MBU informed them that Pippa was in isolation and could not be transferred. It was agreed her bed would be held until the following Monday 31 October 2016. Despite being considered too physically unwell to be transferred to Chelmsford due to risk of infection, Winchester MBU continued to plan Pippa's release on home leave that day stating that "she would not need to be in isolation at home".

93. At a meeting with the Ward Psychiatrist on 27 October 2025, the prospect of Pippa's home leave continued to be discussed with her and her husband The Southern Health Investigation Report records that it was considered "more practical for her" to go home, without assessing the risk that her family might contract the same illness being contained on the ward. In his letter to his MP, her husband describes that staff at Winchester MBU felt strongly that Pippa's mental health was worsening "due to her loneliness and isolation from being so far from home and loved ones", which was the main contributing factor in the decision to send her on leave.

94. We now know that the Ward Psychiatrist took the meeting with Pippa and her husband to assess her leave, and did not consult with the Consultant Psychiatrist about the decision. Nor was the conversation recorded on the Ulysses safeguarding system. Instead, Pippa's records were updated retrospectively after her death, so the staff providing her with remote care by telephone after her discharge had

no contemporaneous records of both the ligature attempts or the risk assessment before Pippa was released (see further from paragraphs 87 and 94 below).

95. While the Southern Health Investigation Report records that Pippa was consulted about being released on leave, she was clearly conflicted, reporting being scared about going home whilst also excited about seeing her eldest son. Her notes show her swinging between wanting to end her life and feeling "fine", sometimes several times a day. The Southern Health Investigation Report claims that the risks of returning home were "thoroughly discussed" with Pippa's family, yet, no family were contacted about her care except her husband [I/S] even though other relatives were expected to take care of her and the baby whilst she was on leave. The report also refers to "a detailed Risk Management and Crisis and Contingency Plan" being drawn up, but I have never seen a copy of this.

96. Instead, Pippa was given a print-out with generic guidance about stress and anxiety. In the Southern Health Meeting Transcript after Pippa's death, her husband raised concerns that this help sheet included "no mention of suicidal thoughts or depression" Pippa's husband emphasised that he and Mum needed help with "how to handle that [Pippa's suicidal ideation]" but did not receive any when she was sent home. This shows the disparity between her husband's concerns raised in the meeting with the Southern Health Trust investigating officer in November 2016, and Southern Health's Investigation Report, which states that her husband felt that he and Mum could keep Pippa safe at home.

97. I am in disbelief that Pippa would have had a better chance of improving at home with the care of her family who had no training or knowledge of how to deal with her condition, rather than within a specialist unit designed to treat patients in crisis. Her husband and mother were effectively put on suicide watch, whilst also looking after two young children and being exposed to a virus, which would ultimately incapacitate them both.

Discharge to the community – *27 October 2016*

98. Despite having told the Chelmsford unit that Pippa could not move to their MBU due to diarrhoea and vomiting, she was sent home with her husband on Thursday 27 October. Knowing that Pippa had demonstrated variable and unpredictable changes in mood, had requested a transfer to an acute ward on multiple occasions and had made several attempts at both self-harm and suicide in the last few days, it is my view that basing the decision to discharge on Pippa's self-reporting was inappropriate.

99. There is very little in the Southern Health Investigation Report timeline about Pippa's discharge planning, save for an intention for her to stay at home until Saturday 29 October before returning to Winchester MBU to subsequently be transferred to Chelmsford MBU on Monday 31 October. It seems utterly nonsensical to me that she would travel all the way home, with a plan to return to Winchester before once again being transferred to the MBU in Chelmsford near where she lived. This shows a clear lack of planning or consideration for how best to ensure a safe transfer for her between MBUs. There was also no home treatment care plan in place for this break between inpatient admissions.

100. There is also no record in the Southern Health Investigation Report that the community mental health team, or the Chelmsford MBU holding a bed for her, were notified that Pippa would be at home in Essex over the weekend. The only care put in place to support her - at a time when she was in mental health crisis and suffering physical illness - was a scheduled phone call from the Winchester MBU the following day.

101. The Southern Health Investigation Report records that a student healthcare support worker from Winchester MBU contacted Pippa by telephone at home on 28 October 2016. During this call, she reported immediately that she "wanted to die", and that she had plans to go for a walk by herself. There is no evidence of the caller responding in any way to Pippa's statements other than recommending that she should not go out alone and encouraging her to "keep herself safe". The student healthcare support worker informed the nurse in charge at Winchester MBU about the call and agreed a follow-up call later that evening. Despite knowing that she was high-risk, and expressing suicidal thoughts, no staff at Winchester MBU thought it was necessary to visit Pippa at

home, bring her back into their unit, or arrange for her immediate transferral to Chelmsford MBU where a bed was already waiting for her.

102. That day, Pippa told our Mum "I thought I would be better at home, but I'm not". She did decide to still go out for a walk, accompanied by her husband and children. Whilst they were out, she asked if they could walk towards the railway line but her husband told her it wasn't a good idea and took her back home.

103. That evening, during a further telephone conversation with the student healthcare support worker from Winchester MBU, Pippa reported feeling better, and this statement was readily accepted without any further interrogation, despite Pippa's notes suggesting that she frequently had mood swings throughout each day and that she had been untruthful when asked about her emotional state whilst an inpatient on their ward. At no point did the healthcare support worker speak to any other member of Pippa's family to verify what she was telling them.

104. This was the last time Pippa had any contact with health professionals. No one visited her at home, so they were not aware that her husband, Mum and Pippa's eldest son had all contracted Pippa's vomiting illness and were incapacitated. She did not tell staff this when they phoned.

105. The following morning, in a short period when both her husband and our Mum were recovering in bed having been ill throughout the night, Pippa quietly absconded from the house, walked down to the train station and towards a level crossing. She saw an acquaintance who spoke to her, but as a train approached, she moved towards it; the acquaintance attempted to restrain her but she pulled away and stepped in front of the train, losing her life.

106. Around this time, her husband realised that Pippa was not in the house and immediately walked down towards the railway station where he discovered the emergency services on the scene, who would not initially let him approach. Later that day, Pippa's husband phoned the Winchester MBU to inform them that Pippa had died.

Concerns about Pippa's diagnoses, treatment and care

Diagnoses

107. As I have mentioned previously, I only found out about Pippa's bipolar disorder diagnosis after she died, which was a huge surprise to me. Neither Mum nor Pippa's husband **[I/S]** both of whom had known about her diagnosis earlier, believed that Pippa actually had bipolar disorder.

108. A close family member suffers from this condition, so I have first-hand experience observing him when he is in a manic state or has not taken his medication. However, during Pippa's life, I never witnessed her experiencing any kind of mania. Her usual demeanour was relaxed, laidback and easy to talk to. Everyone loved confiding in her because she made them feel comfortable and listened to. If Pippa did indeed have this illness, she was incredibly adept at masking it, even from the people closest to her.

109. That said, it is well known that sleep deprivation can be a trigger for episodes of psychosis in patients with bipolar disorder, which could be what happened each occasion after Pippa's children were born. In a joint literature review from Leeds Teaching Hospital and the University of Leeds from 2023, it states: "Studies suggest that the elevated sensitivity to the mania-inducing effects of sleep loss for women with bipolar disorder cannot be denied and it could be concluded that sleep loss is a more potent trigger in women who are already biologically predisposed to the disorder. This not only assists in the identification of women for whom obstetric staff may need to pay particular attention to the protection of sleep, but potentially aids with challenging decisions regarding medication use during the perinatal period."[13]

110. I believe that Pippa's diagnosis of Puerperal Psychosis after the birth of her second son was accurate, however the response, treatment decisions and care provided – or not provided - was inadequate for the reasons I have set out in this statement. Multiple opportunities to support Pippa and provide her with specialist treatment at an early stage were missed, and continual transfers

[13] https://blogs.bmj.com/ebn/2023/01/15/sleep-deprivation-and-its-relationship-with-the-developmen-of-postpartum-psychosis/.

between units and hospitals only worsened her condition and jeopardised her recovery (see further from paragraph 133).

111. Dr Davidson (expert witness) in his evidence on 8 May 2025 explained that "evidence shows that the longer someone is in a state of psychosis, the more harms they will suffer and the more disabilities that will occur, and the harder that it is to treat. The purpose is to get them to a specialist team as quickly as possible so they could get access to the best treatment for early psychosis as soon as possible." It is my view that denying Pippa's requests for transfer to acute wards delayed her receiving proper treatment, and therefore will have exacerbated her deterioration.

112. I am not aware of any other medical diagnoses at that time from the records that I have seen to date.

Medication

113. I believe that some of the medications which Pippa was prescribed in 2016 to treat her psychosis were inappropriate. Her husband raised this in November 2016 with the investigating officer from Southern Health Trust, asking "Did she have the right treatment?" as "she had got better before [after her first child was born]". Our Mum was also concerned about the prescription of Fluoxetine, which she stated at that meeting "made her [Pippa] go downhill so fast". The Southern Health Meeting Transcript shows that the investigating officer stated that they were committed to finding out more about Pippa's treatment and would add it to the terms of reference for that internal investigation. However, the final Southern Health Investigation Report does not consider the appropriateness of the medication or other treatment administered, and only reproduces a list of Pippa's medications during her admission at Winchester MBU from her electronic patient record.

114. In my Opening Statement I also raised concerns, with particular reference to Fluoxetine which has side effects including inducement of suicidal thoughts. In an article from The Journal of Emergency Medicine[14] from as far

[14] https://www.sciencedirect.com/science/article/abs/pii/0736467994904227.

back as 1994, it states: "recent studies have suggested, however, that fluoxetine (Prozac) may in fact lead to suicidal behavior because the drug appears to adversely affect serotonergic neuronal discharge and induce an akathisia-like extrapyramidal reaction. While fluoxetine (Prozac) has a very favorable side effect profile compared to the tricyclic antidepressants, it may cause akathisin and induce a small subset of patients to consider or attempt suicide" [*sic*]. It does not appear to me that this risk was properly considered by prescribing clinicians, or the impact it might have on Pippa's ability to recover. This remained the case even when it was clear she was unable to remain safe in the community, and was re-admitted several times into inpatient care.

115. After Pippa was discharged from Staffordshire MBU, she was prescribed Olanzapine. In her diaries she describes this medication giving her headaches and making her feel drowsy and dizzy. Pippa was not, as far as I know, offered lithium, which is a tried and tested medication frequently offered on the NHS[15], that effectively treats mania, bipolar disorder and can help reduce self-harming behaviour. There is evidence to suggest that Olanzapine combined with lithium can improve the efficacy in treatment of post-partum patients. A recent case study from 2021 states: 'in women with BD [bipolar disorder], the postpartum is a particularly critical period. According to a recent meta-analysis, the overall postpartum relapse risk is 37% in women with BD but 66% in those who were medication-free during pregnancy and lithium is still considered the Gold Standard treatment for the BD. It prevents manic, depressive, and mixed episodes effectively, with robust evidence, supported by recent both controlled and observational studies. Independently of its mood-stabilizing effect, lithium has unique anti-suicide and neuroprotective properties. In addition, it is the only drug that has been shown to be highly effective for the acute and maintenance treatment of postpartum psychosis'[16]. This evidence suggests that if Pippa had been prescribed medication like lithium during her pregnancy, her chances of developing postpartum psychosis could have been significantly reduced.

[15] https://www.nhs.uk/medicines/lithium/about-lithium/.

[16] https://scholars.direct/Articles/psychiatry/jptr-3-009.php?jid=psychiatry.

116. The NEPT Care Plan states that Pippa was given a prescription for sleeping tablets, but to my knowledge she didn't take any as she could not be reassured that they were safe to consume whilst breastfeeding and she didn't want to risk harming the baby. It does not record her being prescribed any other medication upon discharge.

Information about her condition

117. I have found a document entitled 'Your Safety System – a User's Guide' amongst Pippa's papers. It explains how the human body responds to perceived threats through 'fight, flight or freeze', and the effect that high levels of stress and anxiety can have on a person, as well as breathing techniques to manage stress responses. I don't know if Pippa was given this as part of her treatment by one of the hospital trusts responsible for her care; it appears to be the help sheet which her husband referred to in the meeting with the Southern Health investigator (see above at paragraph 96).

118. It is my belief that this document contained such generic information that it proved insufficient to support Pippa at home, as I also discovered a number of other resources which she had printed out herself on Friday 13 September 2016: a) 'My experience of post-partum psychosis' prepared by the mental health charity Mind; b) 'Post partum psychosis' published by NHS Choices; c) 'Postpartum psychosis: severe mental illness after childbirth' published by the Royal College of Psychiatrists; and d) 'Postpartum psychiatric disorders' authored by MGH Cener [sic] for Women's Mental Health. Pippa, as her mental health was worsening at home, sought out advice and further information online to find out more about her condition, its symptoms and how to cope. This demonstrates that she did not already have these resources provided to her, either by Stafford MBU or the Essex Community Mental Health Team. If Pippa had been properly informed about her condition, it seems unlikely to me that she would have needed to seek out further information online.

In-person care and treatment

119. With respect to her in-person care and treatment, because I have not seen her medical records, it is very distressing to think about some of the

experiences Pippa may have endured whilst she was under inpatient mental health care. From what I do know, Pippa requested a referral to an acute mental health ward repeatedly whilst on various MBUs including Broomfield and Winchester, and was refused each time, the decision being deferred to a later date in the hope that she would get better without any further intervention or treatment.

120. I also suspect that the disruption on the maternity ward of Broomfield Hospital in June 2016 may have brought on a period of mania which led to Pippa's post-partum psychosis. The NEPT Care Plan failed to assess the risk that noise on the ward and lack of sleep posed to her as a high-risk patient. Even though Pippa had a history of mania following the birth of her first child, and had been told by a medical professional that there was a 50% chance that it could happen again with another pregnancy[17], to my knowledge she received no specialist midwifery support or preventative measures to minimise the risk of her becoming unwell again. Instead, upon discharge, after expressing concerns about her mental health and requesting a referral to specialist services, Pippa was sent home.

121. In my view, reducing the regularity of her observations whilst on the Winchester MBU in October 2016 was dangerous, given Pippa was expressing suicidal intentions almost daily, and she was allowed to tie a ligature around her neck twice whilst under their care. I don't understand why her dressing gown cord, a clear ligature risk, was not confiscated from her upon arrival; I am incredulous that it was still not removed from her after she was observed with it tied around her neck, and she had to volunteer the ligature to staff herself in order to protect her from further harm.

122. I am not aware of the Home Treatment team, or any other specialist mental health clinician, visiting Pippa in person in the community after 21 June 2016. It is quite possible that they were not even aware that Pippa, who was a high-risk patient, was in the community in Essex from 27 October 2016 as she was not due to be transferred to the Chelmsford MBU until the beginning of the

[17] Southern Health Meeting Transcript.

following week. I consider this to be a major omission in her continuity of care between home stays and hospital admissions and it demonstrates a lack of follow-up from NEPT who should have been liaising with Winchester MBU about plans for her transfer to Chelmsford on 31 October 2016.

Risk assessments and involvement in care

123. I do not have a sense of how involved Pippa was in her treatment or care plans. The only medical documents that I have discovered are neither signed nor dated by Pippa and her responses to questions aren't recorded.

124. I am also unaware to what extent Pippa's ability to mask her true feelings was taken into consideration when care plans and assessments were completed. Responsibility for managing clinical risk is shared between organisations, individual practitioners, service users and their carers.[18] As her sister, I knew that she would often act as though she was fine and in control; in my comments on the Southern Health Meeting Transcript I stated that Pippa was "good at pretending she was fine…she often fought against help as a means to get better by herself" Her husband also confirmed that she would hide most of her symptoms and "didn't want anyone to know". Clinicians could have spoken with her husband privately when risk assessing Pippa's treatment, or discharge planning, so he could speak candidly with them about his concerns. Instead, they took Pippa's self-reporting and desire to go home at face value, despite her multiple attempts to harm herself both in the community and on the ward.

125. As I have said previously, I have seen very few documents relating to Pippa's care under NEPT or other trusts. Paragraph 10.1 NEPT Clinical Risk Management Protocol [2013 edition][19] refers to a series of "agreed, validated risk assessment tools" which may be used by practitioners in completing risk assessments. It provides a list of tools which the Trust recognises, noting that some require specialist knowledge and / or training to implement correctly. Use of other specialist tools are prohibited unless they have been approved in

[18] See for example paragraph 4.5 NEPT Clinical Risk Management Protocol 2013, Exhibit MK-030 of *Assessments and Routes to Admission*, Exhibits Bundle, which is likely to have reflected national approaches to managing clinical risk.
[19] See MK030 of *Assessments and Routes to Admission*, Exhibits Bundle.

advance. I can only assume, as they have not been requested by the Inquiry, that similar tools are used by other trusts nationally.

126. Although I do not know which tools may have been used in Pippa's case whilst being treated by NEPT under this protocol in 2016, I have considered those which relate to suicidal ideation and self-harm (page 18, 28, 33, 36, 38). The number of tools available and lack of clarity about when they were used, coupled with the experiences of other Core Participants whose loved ones were also subject to inadequate risk assessments, leads me to conclude that they are inconsistently and ineffectively applied. I have considered this in my recommendations from paragraph 191.

127. In his oral evidence, Dr Davidson (expert witness) was critical of the current approach to risk assessments, noting that they have become a "hoop" for clinicians to jump through rather than a meaningful balancing of the potential risks and harms of a proposed course of treatment against its therapeutic benefits, to be undertaken with a vision of the patient themselves.

128. Risk assessments about Pippa's care, and particularly her discharge, were clearly misguided. Clinicians' views that Pippa could be kept safe at home, despite being at very high risk of suicide, guided her husband in joint discussions about her care. It should have been recognised that it was disproportionate to place the burden on her husband who was also under pressure from Pippa herself, to take full responsibility for her safety and care (see further from paragraph 154 below).

129. In the Southern Health Meeting Transcript, Pippa's husband asked how the risk assessment and decision to release Pippa was taken. This shows a clear lack of communication and understanding between Pippa's husband and the Winchester MBU staff on the basis for the decision to send her home.

130. The omissions in Pippa's risk assessments could be due to a lack of consistency in Pippa's care, exacerbated by poor record keeping of incidents (see paragraph 87 above). However, clinicians who frequently deal with people suffering with similar illnesses to Pippa's should have been more attuned to the clear warning signs that she was unable to keep herself safe.

131. It is my belief that Pippa was discharged home from Winchester MBU on 27 October 2016 due to pressures of the system to 'free up bed space' before she was moved to another MBU. In a text message from Pippa's husband to Pippa that morning, he reported being informed by staff that it was common practice for patients "who are sick to recover at home where possible". This cannot always be the best approach. In Pippa's case, the risk assessment allowing her to go home, with no clinical support, was a critical point of failure in her care and one which I believe was a major contributing factor to her death.

132. Even in the expert evidence of Dr Karale, and EPUT's documentary evidence, there is an emphasis on returning individuals to the community at all costs, and a permeation of terms such as "positive recovery". I accept that there are many factors at play in making these decisions, but it is my contention that the assessment of harms likely to arise in inpatient settings, on the one hand, versus discharge to the community, on the other, has become imbalanced, and needs to be reconsidered on a systemic basis. If this process of assessment was functioning properly this Inquiry's role would be redundant, and I urge the Chair to look more broadly at the underlying principles driving the clinical approach to the relevant decision-making as well as whether those principles are being applied correctly in individual cases.

Transfers, discharge and Out of Area Placements

133. As mentioned in my Opening Statement, I believe that the distance between Pippa's care settings and her home significantly impacted on the effectiveness of her treatment and was detrimental to her recovery. I am keenly aware that there are limited resources for mental health patients who are new mothers, and I believe that at present there are only 19 MBUs in England, 2 in Scotland and 1 in Wales. I am also aware that many of the units which do exist have fewer than 10 beds in them. The national charity Action on Post Partum Psychosis states on its dedicated page about MBUs that: "There are many parts of the country with no units. Even where there is an MBU nearby, there may not

be a bed available. You may have to be admitted to a general psychiatric ward".[20]

134. Due to limitations in the data produced to the Inquiry, as acknowledged at paragraph 182 of the witness statement of Alexandra Green (EPUT), and the potential issues with AG2-001 itself, which does not appear to reflect the numbers of out of area placements shown in Table 8 of that paragraph 182, it is difficult to know how many other patients may also have been transferred across the country. However, AG2-001 does show that Pippa, and many other patients like her, had to receive out of area care due to capacity issues. The impact that lack of local provision has on the welfare of patients should, in my opinion, always be taken into consideration when planning treatment and transfers.

135. Winchester MBU acknowledged that Pippa's mood often improved when she was in close proximity to her home and had contact with her family; in fact, this was the main motivation behind sending her home on overnight leave in late October 2016. At a meeting in November 2016 held with the investigative officer from Southern Health, I inquired as to why there was only the binary choice of keeping Pippa as an isolated inpatient many miles away, or discharging her home without support. I was not provided with an answer, and when my suggestions for other feasible alternatives were omitted from the Southern Health Meeting Transcript, I included them in comments, dated 12 December 2016. These included the possibility of a) Pippa's husband staying overnight on the ward with Pippa and the baby (or nearby), b) a video call home rather than overnight leave, c) a home visit from staff to check in on Pippa rather than a phone call. No reference to my suggestions was ever included in the Southern Health Investigation Report.

136. Pippa is not here to tell us how her out of area placement affected her, we can only remember the multiple occasions she begged staff to move her closer to her family, even if that meant leaving an MBU environment to move to an acute psychiatric ward instead. However, another new mum, Nia, who

[20] https://www.app-network.org/get-help/mother-and-baby-unit/.

experienced a similar episode of post-partum psychosis (three years after Pippa's death in 2019) shared her story publicly and explains how the distance between her home in North Wales and her treatment at an MBU in Manchester critically affected her: "I was grateful to have access to an MBU, as it meant that I was able to stay with my baby. But the fact that we had to travel two hours from home made life really difficult. Each day, my husband was travelling for four hours between the hospital and our home, and doing a full-time job in between all the travel. The stress he was under was immense. Regardless, Tommy continued to visit every day and that's something I am so grateful for because, when you're in hospital so far from home, it can feel really isolating and lonely. Two hours is a long time when you're in mental health crisis. I did make some friends in the MBU, but when you're so far from home it makes everything feel ten times harder".[21]

137. Exhibit AG2-001 appears to show that Pippa was also bounced between Chelmsford and Nottingham as well as Staffordshire and Winchester, in addition to having several periods under the care of the Home Treatment Team. I don't know why Pippa was rejected from the Nottingham MBU, or if indeed this even happened, or why she was admitted to Winchester rather than returned to Staffordshire in October 2016. Whilst it may have been the closest bed available to her at the time, the clinicians there did not know her and she had to once again adjust to another new environment rather than receiving continuity of care. I believe that this multitude of placements and transfers had a detrimental impact on her ability to recover, which is demonstrated by her rapid deterioration during those short months.

138. Not only this, as highlighted earlier in my statement (see above from paragraph 34) the NEPT Care Plan was inadequate in preparing for Pippa's transfer to the community. This contravenes paragraph 24.3 NEPT Care Programme Approach (CPA) and Non CPA (Standard Care) Policy and

[21] https://www.app-network.org/ourstories/nias-story-i-had-to-travel-many-miles-from-home-to-access-an-mbu/.

Procedure[22] of a "current and coherent care plan when they [patients] transfer" which includes any changes in need or circumstances and risk factors.

139. It is also worth highlighting that had Pippa been moved to an acute ward in Chelmsford, as she requested so many times, she could have seen her family on a much more regular basis and at shorter notice, removing the need for her to go on home leave in the first place. This is supported by evidence provided by Dr Davidson (expert witness) at the hearing on 8 May 2025, who confirmed that evidence shows a correlation between out of area inpatient treatment and negative impact, such as increased recovery time, increased instances of self-harm, and even suicide.

140. In the evidence provided to the Inquiry by Dr Karale (EPUT) regarding the Inpatient Pathway, reference was made to a Care Coordinator' who has responsibility for the oversight of care for any Essex-based patients, even when they are transferred out of EPUT services. It is clear that when Pippa was receiving her treatment, this role was either not in place or was not functioning properly; she was continually discharged and readmitted to various units across the country over a matter of weeks, with no oversight on how her overall recovery or deterioration in condition was developing. This is at odds with what the position should have been, according to Dr Karale: "it must be clinically appropriate for a patient to be placed out of area, proportionate to any risk, and local responsibility and involvement must be maintained[23]."

141. Hearing the evidence provided to the Inquiry at the April 2025 hearings, it has become evident to me that NHS trusts are under immense pressure to get mental health inpatients back into the community as soon as possible. Dr Davidson's evidence on 8 May 2025 was that longer periods of inpatient treatment do not necessarily lead to better outcomes. This may be true as a general point, however I am seriously concerned that this has enabled the practice, described by Dr Karale in his oral evidence on 13 May 2025, of arbitrarily fixing 'target' discharge dates within four weeks of admission.

[22] See MK-020 of *Assessments and Routes to Admission*, Exhibits Bundle.
[23] See also NHS England Standard Operating Procedure on Commissioning Specialised Services 2020, transcript of 13 May hearing.

Discharge is based on completing a series of 'tasks' after which time a patient is assumed to be recovered or 'well enough', rather than a holistic approach specific to the individual being treated. I am keen to understand through the Inquiry's questioning of oral witnesses why this approach, which relies heavily on overstretched Home Treatment Teams as a safety net for "positive risk taking", is considered acceptable practice. In Pippa's case, her repeated admission to inpatient settings with very short gaps in between demonstrates that she was not well enough to be discharged in the first place, and that there is a fatal flaw in the current system. This is reflected in the experiences of many of the Core Participants in this Inquiry. I would encourage the Inquiry team to consider undertaking further investigation into readmission statistics, and whether there has been a notable difference in relapse and inpatient readmission since the adoption of the '4 week discharge target' approach within EPUT's units.

142. The abdication of responsibility by the trusts involved in Pippa's transfer from Winchester to the community (prior to her planned admission to Chelmsford MBU) on 28 October 2016 left Pippa fending for herself at home without support, in my view having been discharged too early, whilst technically still under the care of Southern Health Trust hundreds of miles away. The role of a 'Care Coordinator' could have prevented her falling between the gaps at a critical point of deterioration.

Safety

143. To my knowledge, Pippa was not physically or sexually abused whilst an inpatient at any of the hospitals I have mentioned. However, as we have never seen full records from any of her stays, there is no way for me to know exactly what happened to her. We do know for certain that Pippa's stay at Broomfield Emergency Department was a highly traumatic experience for her (set out at paragraph 48 above). I have been told by Pippa's husband and our Mum that she was restrained and handcuffed to a bed in the Linden Centre in Broomfield, which would have made her incredibly vulnerable. I do not know why this was considered necessary, or if any justification has ever been recorded. Paragraph

11.17 of the 2023 Health Based Place of Safety Operational Policy[24] requires a formal record to be made that a person's capacity has been appropriately assessed, to avoid unauthorised deprivation of liberty. I have seen no such record from Broomfield Emergency Department. To me, it seems a heavy-handed and oppressive way in which to treat patients who are experiencing mental health crises and should only be used as a last resort. It is possible that Pippa suffered mistreatment during her stay, but I will never know for certain unless staff or patients who observed her at that time come forward to give evidence to this Inquiry.

144. Pippa was clearly a danger to herself during the period under investigation by this Inquiry. I don't know if she was at risk of harming herself whilst staying as an inpatient at Broomfield Emergency Department or the Chelmsford Ward in early October 2016 as there are no diary entries or medical records for her treatment by NEPT. I do know for certain that during her time at Winchester MBU and whilst at home, she made multiple attempts to harm herself and commit suicide. I can only presume that she was similarly inclined whilst on other wards, during periods of mania, including those run by NEPT. However, I do believe that Pippa was trying to seek help through writing in her diaries about how she was feeling and reporting to people around her when she attempted to harm herself.

145. Pippa's discharge from Winchester MBU not only put her at the very high-risk of self-harm, but also jeopardised the safety of her family through the transmission of the virus that she contracted on the unit. In addition, Pippa reported to staff that she felt unable to care for her baby, both on the unit and at home, so it was quite possible that the baby could also have been at risk when Pippa was discharged.

146. To my knowledge, Pippa never felt threatened by other patients or members of staff in the Stafford or Winchester MBUs, although I do feel that she suffered neglect of care in Winchester due to the clinicians' dismissal of her reports of suicidal ideation and failures to adjust her treatment.

[24] See MK-032 of *Assessments and Routes to Admission*, Exhibits Bundle.

Engagement

147. Dr Davidson (expert witness) in his oral evidence noted that families should be a key source of information if they are available, and can help clinicians to understand a patient's usual behaviour and history.

148. As I was never contacted by any of Pippa's medical teams about her care, I had very little understanding of Pippa's admissions and discharges, her treatment or the decisions being made about her care. I also could not have contacted the relevant trusts with any concerns about her.

149. As previously mentioned (see paragraph 84 above), I did manage to phone Pippa directly whilst she was staying at the Winchester MBU, but this was only because I felt determined to get in touch with her.

150. Although the clinical staff were in contact with Pippa's husband and he was able to make many visits to her, as far as I am aware there was no suggestion or encouragement from the hospital staff for Pippa's family or friends to visit, or to even contact her, which is concerning given Pippa was already geographically isolated. The lack of engagement from Pippa's treating clinicians gave relatives the impression that we should not contact her, as it could impede her recovery.

151. As far as I know, all correspondence and discussion relating to Pippa's treatment was with her husband **[I/S]** Our Mum was never consulted directly - even though she was frequently staying at Pippa's house to support with childcare and was a crucial part of her support network - so she didn't have the opportunity to report whether she felt able to keep Pippa safe. They certainly never involved me or our siblings in discussions about Pippa's condition and treatment.

152. Pippa's best friend has also told me she only spoke to Pippa briefly on the telephone once whilst she was in hospital throughout those months. I think it would have been beneficial for the trusts responsible for Pippa's care to encourage more communication with her family and friends while she was being treated at distance from her home.

153. Further, the NICE Guidelines[25] discussed on 8 May during the oral evidence of expert witness Maria Nelligan, highlighted provisions that clinicians should be working in partnership with people using mental health services and their families or carers (paragraph 1.1.1), and that the patient should be consulted about if and how they wish for family and carers to be involved in their care (paragraph 1.1.14).

154. Yet at no point in the records that I have seen were Pippa or her husband asked if it would be helpful to have additional support from family members as part of treatment or discharge planning. It must have been incredibly difficult for her husband to shoulder the responsibility for liaising with clinicians on Pippa's treatment decisions on his own, whilst holding down a job and taking care of two young children, knowing that Pippa was hundreds of miles away and in crisis. It seems highly likely that Pippa's husband would have been under pressure to argue for what Pippa told him she wanted, and also to listen to any recommendations that were being made by the expert clinicians.

155. Even after Pippa died, we had no meaningful opportunities to engage with the organisations which had been responsible for her care, or those undertaking investigations into her death (see further from paragraph 166).

Absconsion

156. I am not aware of Pippa attempting to abscond from inpatient units, but it is clear to me from her diaries that she was desperate to leave, and masked her true feelings and even physical ill-health in order to be allowed to do so. As I have set out above (see paragraph 124), this was not properly taken into account in risk assessments for her discharge.

157. I have asked the Inquiry in written comments to the CTI papers, alongside other Core Participants, to reconsider the full definition of absconsion. The current wording: "any incident or occasion when a person has been absent from a ward/unit, either expectedly or unexpectedly, in circumstances where that absence could or should be considered as worrying"

[25] Recommendations | Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services | Guidance | NICE.

would suggest that technically Pippa was an abscondee; her absence from both Winchester and Chelmsford MBUs would fall under this description, which was undoubtedly worrying given her suicide attempt immediately beforehand.

158. Even if Pippa won't be classified on this basis, I would ask the Inquiry to consider to what extent masking is taken into account when assessing the wishes of patients who want to go on leave, as Pippa was highly adept at concealing her true emotions and left the ward with the sole intent of ending her own life.

My knowledge of events leading up to Pippa's death

159. On the morning of Saturday 29 October 2016 I was at home with my husband. At around 10am or 11am I received a phone call on my mobile which displayed 'Pippa' and I knew instantly that it was my Mum calling from Pippa's house as she was staying with them at the time; I instantly felt that something terrible must have happened. As I answered, the other end of the line was silent, but I could hear Mum sniffing. I asked "What's happened?" and Mum replied: "The worst." I knew then that Pippa had died. My Mum told me that she had been hit by a train. She was extremely upset and couldn't speak to me at length. She explained how they had been very ill throughout the night and that in the early morning realised Pippa was no longer in the house. She went on to explain about Pippa's walk towards the railway line the previous day and how Pippa's husband found the emergency services at the scene.

160. When Mum gave me the news, I was in shock, but it wasn't a total surprise as I had been fearful of Pippa's state of mind following our phone call earlier that week. I had been in contact with my Mum on the days in between and she had reported that Pippa had been doing better and appeared in good spirits, so I had allowed myself to believe that she was improving. As I was the first person Mum informed of Pippa's death, I suggested that I phone the rest of the family that day so Mum would be spared from having to retell what had happened.

161. We were all in shock and needed some time to get our bearings. We agreed that I would come over to the house the following day so that Pippa's

eldest child could be informed. My husband stayed with me, and I spent the remainder of that day calling various members of our extended family.

162. I did not have any direct contact from the emergency services, hospital or local authorities to tell me that Pippa had died. Pippa's husband found out what had happened when he arrived at the railway station that morning from emergency service workers who were at the scene. I do not know if the police or any other emergency service personnel visited Pippa's husband on the day of her death.

163. The following day, 30 October 2016, I travelled with my husband by taxi to Pippa and her husband's house [I/S] We do not have a car, and I did not want to take the train given what had just happened. My eldest sister [I/S] and her husband also visited that day, along with Pippa's husband's mother and his brother, who were both helping Mum to look after Pippa's children. Pippa's husband stayed in his bedroom most of the day. When we did see him, he was evidently in shock and still trying to process what had happened the day before. He told us that the previous night their eldest child had a nightmare where he was being attacked by zombies, but that Pippa had arrived doing cartwheels and fought them off to protect him.

164. No one from any emergency or support services came to the house to speak to us at all during that day.

165. In the weeks and months after Pippa died, we were wrapped up in a whirlwind of arranging the wake and funeral, and Pippa's husband had the additional pressure of dealing with the local authorities and transport services about her inquest and autopsy whilst also acclimatising to the new pressure of being a single Dad with a very young baby. I was even contacted by the local press who wanted to write a story about Pippa's suicide. I asked them to be considerate in their tone, emphasising that Pippa had young children who might see the reporting one day and reminded them that she had been a pillar of the community for many years.

166. Although I did not know the details of Pippa's autopsy or inquest requirements, they did delay the funeral by a few weeks, which eventually took place on 3 December 2016.

Investigations around Pippa's death

Southern Health NHS Foundation Trust Investigation

167. On 28 November 2016, a month after Pippa died, a female representative from Southern Health Trust came to Pippa and her husband's house to speak to our family as a group, including myself, our older sister Mum, **[I/S]** and Pippa's mother-in-law. They told us that they were the investigating officer completing an internal investigation into what had happened to Pippa and that we would have the chance to comment on a draft report before it was finalised. The only person I ever spoke to about the investigation was this officer. I do not know which other clinicians may have been involved or who provided information towards its conclusions as they aren't named, but staff are referred to by anonymised codes. I cannot recall how long it took to finalise the investigation report; I received a draft copy to offer feedback in December 2016 and the final copy that I have is undated. Given there are discrepancies regarding Pippa's admission date and bipolar diagnosis (see above paragraphs 23 and 50), I have no doubt that there are many other errors within the Investigation Report.

168. The investigating officer mostly asked about Pippa's childhood and her mental health history, instead of her recent treatment. It felt as if the officer was trying to put together a picture of Pippa as someone who had been suffering from constant mental ill health throughout her whole life. The truth is, Pippa was an incredibly jovial, fun and free-spirited person (see my Opening Remarks to this statement). We tried to explain this to the investigating officer, but as a stranger who didn't know Pippa as a person, as complex as she was, it felt as if her character was being misunderstood as a depressed and deeply unwell woman, rather than the person who we knew was wonderfully full of life and laughter.

169. Following the meeting, I do not recall if the investigating officer offered our family access to any emotional support, but it is recorded in the Southern Health Meeting Transcript that this was provided. At that time, I think most of us were still in shock from what had happened. We were being asked to unpick what had led to Pippa's death, when she hadn't even been buried yet. I was in

the throes of arranging her wake, which was taking place a few days later. We were not given any detailed information, such as a leaflet or pamphlet explaining how to seek support after her funeral or how to contact anyone from Southern Health after the visit.

170. Following the meeting we were provided with the notes the investigating officer had taken (Southern Health Meeting Transcript). I made several significant corrections to this document, which are included in tracked changes dated 12 December 2016, and returned it to the Southern Health team via Pippa's husband I felt that the meeting notes mispresented the discussion that had taken place and was inaccurate in respect of some of Pippa's medical history, which I sought to correct. Despite this, my comments were ignored, and many inaccuracies were included in the final Southern Health Investigation Report presented to the Coroner at Pippa's Inquest. I have set these out at relevant points throughout my statement.

171. I recall receiving a copy of the final Investigation Report by Southern Health Trust from Pippa's husband whilst I was at work. At the time, I was in a short-term contract for the Culture Team at the Mayor of London's Office, which means that this would have been at some point between 16 January 2017 when that role started and the date of Pippa's Inquest which took place on 22 February 2017.

172. I clearly recall reading the report on my lunch break and feeling sick to my stomach with the information in front of me. I had received no warning about its contents. Aside from the serious misrepresentation of Pippa's character which I've outlined above, this was the first time I was made aware of the details, and failures, of her treatment. Until this time, I genuinely believed that Southern Health was not aware of how ill she was and the great risk of harm she posed to herself. I had been informed by the investigating officer that when the ward staff at the Winchester MBU had been informed of her death it came as a total shock to all of them, but her records in the Investigation Report demonstrated obvious warning signs of her deterioration. To read the timeline in the Southern Health Investigation Report, which clearly demonstrated that Pippa was intent on suicide whilst on the Winchester MBU, was horrifying.

173. Most concerningly, the Investigation Report in its conclusions appeared to downplay the many major oversights and poor clinical decisions in Pippa's care. The Executive Summary states: "there is every indication that Pippa received good, individualised and collaborative care, taking her family's needs and concerns into consideration. Pippa sought support from the ward on the day before she died, and was given appropriate support". Pippa's cause of death is recorded as "Probably Suicide in the Community/outpatient"; it suggests they washed their hands of Pippa even though she had not been discharged from the MBU nor safely transferred to NEPT.

174. I disagree with the Investigation Report's conclusions. They are contradicted by the lack of continuity in Pippa's care (paragraph 137 above), poor observations and safety leading to ligature incidents, and failure to keep contemporaneous records of those incidents (paragraph 87) resulting in inadequate risk assessments (paragraph 128), and the decision to send her on leave whilst she was both mentally and physically unwell (paragraph 93). The report does not grapple with the serious issue of the failure to provide appropriate support or to arrange appropriate transfers (paragraph 99), which left Pippa effectively unsupported in the community when in crisis, following a severe and documented deterioration on the ward.

175. Further, the Investigation Report is incomplete in failing to identify the source of information relied upon, and in the limited information-sharing between other trusts involved in Pippa's care in the months leading to her death (see further paragraph 179).

176. In my view, the Report's recommendations are untargeted and flimsy. They do not sufficiently address the many real issues highlighted by the investigation and appear to be worded so as to minimise any responsibility. The lack of acknowledgement of evident failures in Pippa's care is deeply upsetting for me. It is also incredibly worrying, because it suggests that should the same circumstances arise again with another patient, they could be put at very great risk of harm by being sent home before they are ready and with limited or no care between transfers.

177. Sadly, I have never received any update from the Southern Health Trust about whether the recommendations in the Investigation Report were successfully implemented or monitored.

178. I am not aware of, nor does the Southern Health Investigation Report mention, any referrals being made to the Care Quality Commission or Health and Safety Executive with respect to Pippa's ligature incidents.

Staffordshire and Shropshire Healthcare NHS Foundation Trust Investigation

179. I have seen from Southern Health's Investigation Report that there was an investigation undertaken by Staffordshire and Shropshire Healthcare NHS Foundation Trust, who were responsible for Pippa's care when she was admitted to the Stafford MBU in June 2016. I have never seen a copy of any report produced about Pippa's time as an inpatient in Staffordshire, nor been contacted by that trust.

Pippa's inquest

180. Pippa's inquest took place throughout the morning of 22 February 2017 at Chelmsford Coroners Court and was completed just after lunchtime. I attended with my husband, Mum and Pippa's husband as well as my sister **[I/S]** and her husband. We did not have any legal representation. No one had explained the process to us or what we should expect beforehand. None of the family were offered the opportunity to participate in the hearing. The only information that I received was via Pippa's husband who told me that I could come and listen to the evidence being given. I did not know at the time what was meant by an Interested Person in inquest proceedings and I was not told that we could apply to have a participatory role.

181. The only other person who attended the inquest to give evidence was the investigating officer from the Southern Health Trust. There were no representatives from any other organisation, such as the other trusts involved in Pippa's care, or the emergency services. Had I been given the opportunity, I would have liked to ask some questions of the investigating officer due to my concerns about the final Investigation Report.

182. After the Southern Health Trust's evidence, the Coroner asked some brief questions and then gave a short conclusion in which she stated that Pippa's death was a terrible tragedy that was avoidable.

183. One week after the inquest, Pippa's husband received a letter from the Coroner dated 27 February 2017. It included the Record of Inquest and simply states that "Pippa killed herself". To see her experience boiled down to that simplistic phrase was extremely disappointing.

184. I was not aware of the opportunity for the Coroner to write a Prevention of Future Deaths report and I feel that in Pippa's case it would have been appropriate to have one. I did not know that there was an opportunity open to the Coroner to do so, until I was asked about it by my RLR in this Inquiry. With hindsight I feel frustrated that we did not know how to advocate for ourselves in those proceedings so that they might led to useful recommendations which could effect important and much needed changes within the NHS.

185. After the hearing, we as Pippa's family, were taken to a private room. I remember discussing with my relatives my strong feeling that there needed to be further investigation into the protocols around Pippa's release from Winchester MBU. It still made no sense to me that Pippa had been allowed to go home from Winchester MBU the day after she had attempted to kill herself on the ward, and I felt passionately that these mistakes should not be repeated with future patients. However, my family were still very much grieving at the time and did not have the strength or appetite to pursue further legal investigations.

Concluding remarks

186. There were clearly missed opportunities by NEPT, and other trusts, to assess and treat Pippa properly, given her known diagnoses and mental health history. Her family knew she was unwell after the birth of both her children, yet it appears that there was no proactive planning from the trusts responsible for her care to help her manage this, or to assist us to keep her safe. If care planning was undertaken during her pregnancy, then it was either not shared with the appropriate units providing her care, or not effectively actioned by

them. I believe that these, and the other failures I have highlighted through this statement in my sister's treatment and care, significantly contributed to her death.

187. I've heard evidence from other families in this Inquiry who were treated by NEPT, or later EPUT, and they too have been failed by many of the same issues which Pippa faced. This leads me to question whether her care would have been improved had she been in Essex; what I do know is that she would have been closer to home and her support network and this would have helped to negate the deterioration in her condition.

188. This is in contrast to my own experience when I became pregnant with my first child, two years after Pippa's death. I declared Pippa's mental health history to the Community Midwife Team in the London Borough of Redbridge where I live, because I was worried that I might be susceptible to similar difficulties to those faced by Pippa. It was decided, even though I had no history of mental health issues myself, due to my close genetic relationship to Pippa, that I should be referred to a specialist 'Purple' midwifery team who provide additional assessments throughout pregnancy and post-partum to high-risk patients, by looking for any signs of anxiety, stress or depression. Thankfully, I showed no signs of post-natal depression, but I was grateful to be referred to this team as a preventative measure and to have a clearly defined plan and set of notes available in my maternity folder for my birth hospital to view whilst I was an inpatient. This is the treatment that Pippa, a patient with a known history of postpartum mental illness, should have received automatically whilst under the care of NEPT.

189. I understand that the purpose of this Inquiry is not to assign blame, but to uncover truth and to ensure that mistakes are not repeated. I echo the sentiments of many of the other Core Participants, which is that I want NHS services responsible for my sister's care to acknowledge where things went wrong, and ensure that instead of promises of 'lessons learnt', there are practicable and deliverable methodologies for change in practice and patient care. No family should have to suffer the pain of losing a loved one so tragically to suicide, particularly when it is clear that their death was avoidable.

190. With this in mind, I have reflected upon the treatment that Pippa received and request that the Inquiry consider making the following proposed recommendations. If protocols are already in place implementing the recommendations, or following their introduction, the Department for Health and Social Care should monitor their fulfilment.[26]

Recommendations

191. While I understand this is outside the scope of this Inquiry, I believe that the issues addressed in my statement and recommendations below are **systemic** and affect trusts outside of Essex. I ask the Inquiry to recommend a national investigation into these failures across NHS trusts in England.

Training and specialist provision

i. A specialist midwifery team in Essex is assigned to high-risk mental health patients during their pregnancy, to put in place individualised preventative measures, birth planning and post-natal care.

ii. Preventative pharmaceutical interventions are offered to pregnant patients with a history of bipolar disorder and/or post-natal depression throughout the pregnancy period.

iii. Psychiatric liaison nurses are present in Emergency Departments and maternity wards at all times, and that on admission, high-risk patients are provided with a psychiatric assessment as standard within a specified period after arrival.

iv. Trigger lists are included on all mental health patient hard-copy and digital notes as standard, so that clinicians and support staff on acute wards recognise early indicators of crises and red flags specific to each patient.

v. Patients who have presented with psychosis or mania are offered the assistance of an advocate, or other specialist such as a Care Coordinator, to

[26] See for example in relation to the Covid-19 Inquiry Recommendation Monitoring - UK Covid-19 Inquiry.

ensure continuity of care and act as a trusted individual at multidisciplinary team meetings, clinical assessments and treatment discussions with the patient.

vi. All frontline and Emergency Department staff to receive annual training on safe admissions and care for mental health patients in crisis.

Risk assessments

vii. Standardisation of risk assessments nationally to ensure objectivity insofar as possible, preferably using risk numerical weightings and a calculation matrix. This should include exacerbating and mitigating factors to allow clinicians to calculate an accurate overall risk profile, with an agreed risk threshold for each treatment option, reducing disparity introduced by the subjectivity of different clinicians.

viii. Additional safeguarding requirements / measures to be established as protocol after suicide attempts – and factored into numerical weightings in the risk assessment – before a patient can be permitted leave or discharge.

Ward environment

ix. More bedspace is resourced within Essex MBUs as a matter of priority to reduce Out of Area Placements.

x. Additional beds are made available on acute wards in Essex specifically for mothers with young children, so they are not separated.

xi. A list of 'frequently used' ligature objects is published for all acute units, so that these items can be confiscated upon admission.

xii. As recommended by Maria Nelligan (expert witness), implementation or clarification of 'Observations' guidance with consistent standards and terminology to ensure that patients with ligature risks receive heightened observations, requiring 1:1 observations following attempts and near misses.

xiii. Following near misses, refreshed risk assessments are undertaken and documented by a senior clinician within a required time period to identify

immediate changes to treatment plans, prescribed medication and arranged leave.

xiv. Disease and infection control measures are included in any risk assessments drawn up for temporary leave or discharge.

Transfers

xv. For patients with a history of suicide attempts, self-harm or suicidal ideation, plans for transfer between inpatient units, or into the community, must be assessed and signed off by a senior clinician (Consultant).

xvi. Contemporaneous patient records are shared with the treating service providers, including both within Essex and Out of Area, prior to admission of any new patient.

xvii. Individualised risk assessments are carried out before any transfer is agreed, to identify changes in risk parameters (i.e. physical illness, patient masking, availability of support networks etc) as well as to avoid any potential for patients to be rejected by trusts upon arrival. Where risks associated with the transfer have been identified, these should be clearly communicated to the receiving hospital / trust.

xviii. Ongoing liaison is carried out between service providers, including both inpatient and Home Treatment Teams, led by individual Care Coordinators (or named key workers) who retain responsibility for obtaining updates on the patient's care even when Out of Area. Any significant changes in risk or treatment planning should be communicated to all service providers involved in the patient's care so concerns can be reported, or relevant information can be fed to the treating trust.

xix. Essex Support and Treatment for Early Psychosis (ESTEP) team to provide 'At Risk Mental States' services as an immediate response to all patients suffering psychosis, to ensure smooth referral to an appropriate service provider for ongoing care.

xx. Psychosis patients in crisis (including those detained under the Mental Health Act) to be admitted as first priority to the MHUCD in Basildon, rather than Emergency Departments.

xxi. Discharge and leave dates to be communicated in advance to Home Treatment Teams to facilitate a scheduled attendance at patients' home within 24 hours of discharge and temporary leave.

Treatment & Medications

xxii. Further investigation into risks associated with use of Fluoxetine, or other contraindicated medications, for patients with any history of suicide ideation.

xxiii. Clinicians to complete written justification for applying physical restraint of any kind, to be assessed by a second senior clinician following the incident, to discourage unnecessary or excessive use.

xxiv. Protocol of required safeguarding measures (whether delivered on the ward or via Home Treatment team) to achieve numerical risk assessment threshold before a patient can be fully discharged from care.

Crisis Planning

xxv. With the patient's consent (if they have capacity), family networks beyond next of kin to be included in communications regarding care, particularly where leave or discharge is agreed, to ensure robust contingency and crisis planning. Where family members or friends will be included in the patient's care plan in the community, a requirement to consult with those individuals regarding the potential risks.

xxvi. Crisis and contingency plans to be completed in every instance of leave or discharge, including emergency contact numbers for the nearest ward and home treatment services.

xxvii. Crisis Response Service to be notified of any recorded near miss suicide attempts or reported intention for serious self-harm by patients within the

community within four hours, allowing for intervention and, where appropriate, immediate recall to inpatient care.

Engagement

xxviii. Written copies of care plans to be provided to families, setting out the course of treatment for the patient, as well as support advice for family members providing care to the patient in the community.

xxix. Where patient requests (such as for transfers) are dismissed, written record of reasons to be added to medical notes and provided in writing to family members and patients.

Investigations

xxx. Coroners to compel EPUT as the 'home' trust (even where patients are treated Out of Area) to produce written evidence and medical records in preparation for inquests of Essex-based patients.

xxxi. Reflecting on the evidence of Deborah Coles for INQUEST, a 'National Oversight Mechanism' and independent public body responsible for collating, analysing and following up recommendations arising from inquests to be established. The same body to proactively contact families to provide information about the process and make them aware of their rights, and refer them to legal representatives where appropriate.

Statement of Truth

I believe the content of this statement to be true to the best of knowledge.

SIGNED: [I/S]

DATED: 19 May 2025