Monday 20 October 2025

(10.07 am)

THE CHAIR: Ms Troup?

MS TROUP: Chair, today we continue with evidence from the families of those who have died. First this morning we hear from Dawn Johnson and Craig Scott, who are going to be speaking about their mother, Iris Scott. Iris died on 1 March 2014, aged 73, and, Chair, their evidence will cover a very broad range of issues. After lunch we will hear from Robert Wade, who will speak about his son, Richard Wade, and Richard died on 21 May 2015 aged 30. That evidence will include Richard's experiences of mental ill health, his time as an in-patient at the Linden Centre in Chelmsford and his death. The evidence today, again, will inevitably touch on deeply troubling matters. People attending today or watching remotely may find some of the matters distressing, and I would like to make clear that emotional support is available from the Inquiry from those who require it. There are two support staff from Hestia, a provider of emotional support, here today and for each day of this hearing. They are wearing orange lanyards and scarves, so as to be easily spotted and there is a private room downstairs available for people to talk to Hestia staff if needed.

For those watching online, information about

available emotional support can be found at the Lampard Inquiry website at lampardinquiry.org.uk and under the "Support" tab, near the top right-hand corner. We want all those engaging with the Inquiry to feel safe and supported.

Could the witnesses be sworn, please.

DAWN JOHNSON (sworn)

CRAIG SCOTT (affirmed)

Examination by MS TROUP

Q. Dawn, if we start perhaps again with you. Could you state your full name for the record, please?

A. DAWN: Dawn Alison Johnson.

Q. Thank you. The Inquiry sent to you, some months ago a request for evidence under Rule 9 and in response you provided a witness statement. You should have a copy of that witness statement in front of you. It is 42 pages long and dated 9 June this year. If you turn, please, to page 42, it is in fact redacted, but this is the witness statement that you signed and made a statement of truth on that page, 42. Is that right?

A. DAWN: That's correct, yes.

Q. Dawn, are you happy that the contents of that witness statement are true and accurate?

A. DAWN: Yes.

Q. Craig, if I can come to you, can you state your full name

for the record?

A. CRAIG: Craig John Scott.

Q. Thank you. You provided a witness statement to the Inquiry dated 27 May 2025, and looking please at page 12, that is where you made a statement of truth and signed. Is that right?

A. CRAIG: Correct.

Q. And I ask you also, are you content that the contents of that statement are accurate?

A. CRAIG: I am.

Q. Thank you. You are the daughter and son of Iris Scott, who was born on 5 December 1940, and who died at the Crystal Centre on 1 March 2014, yes?

A. DAWN: Yes.

Q. At the time of her death Iris was 73.

A. DAWN: Yes.

Q. You have provided to the Inquiry in Chelmsford, in September 2024, commemorative and impact accounts about the effect of your mother's death on you both and your family, and also telling us about the life of Iris and who she was as a person. We thank you for that evidence and for your evidence today. You give evidence today side by side and, Craig, I understand from your witness statement -- your witness statement is shorter and, Dawn, you have taken us through the chronology of events that

we will come to. But Craig, I understand that you adopt and agree with all of the content of Dawn's witness statement, is that right?

A. CRAIG: I do.

Q. And that your witness statement essentially adds comment or impressions or recollections where you felt able to do so?

A. CRAIG: Correct.

Q. And also gives your own opinions on certain matters that we will come to?

A. CRAIG: It does.

Q. Both of your witness statements, I think, have been prepared obviously from your own recollections, but also following analysis by your legal team of medical records.

A. DAWN: Yes.

Q. I think those include both GP reports and NEPT's records.

A. DAWN: Yes, yes.

Q. We are also assisted by the fact that, Dawn, you kept contemporaneous note of events in your diary.

A. DAWN: Yes, from the December onwards I started to make notes of my own which I kept and asked my mum also to make notes daily because obviously we didn't get to speak to her all the time.

Q. That was going to be my next question. We are also assisted by notes that your mother made and that you now

have?

A. DAWN: Sorry.

Q. Please don't say sorry, it is very helpful. That was at your own request and that was after her admission to Ruby Ward, was it?

A. DAWN: That's correct. That was mainly after the Christmas period, but as I said, just so that if there was anything she couldn't remember, that she would write down to tell us.

Q. We will come to see, I think, why it was that you made that suggestion to her. You both told us a little about your mother when you gave your commemorative evidence. My understanding, and you must correct me if this is wrong, is that her very first episode of mental ill health came in around November 2007. And Craig, you tell us that there was a party in November 2007 for family and friends and what your first noticed was that your mother seemed vert withdrawn, is that right?

A. CRAIG: That's correct, yes. We had family fireworks going, and where my mum would normally be very much the life and soul of any family gathering, my wife and she was the first to highlight to me, "Do you think your mum is okay?" No, she wasn't.

Q. What were her symptoms at that time, it was anxiety, is that right?

A. CRAIG: To be fair, we didn't really -- at that point in time we didn't really know, something was wrong, something was off, whether it was general ill health or mental health, we didn't have an idea at that time, but she definitely was not herself.

Q. I understand. By 30 November her condition had come the point where her GP made a referral to a private psychiatrist, I think?

A. DAWN: We decided to take mum to a private psychiatrist at the Priory in Chelmsford because -- basically to jump the queue and make sure that we could nip things in the bud.

Q. Because you were so concerned about her?

A. DAWN: Yes, she was just, she deteriorated quite quickly over those couple of weeks.

Q. I understand that by early 2008 her condition had deteriorated further and that you made contact with the mental health crisis team?

A. DAWN: That's correct, yes.

Q. On 3 January 2008 your mum was first seen as an outpatient at the Linden Centre; is that right?

A. DAWN: I can't remember the date, but yes, it was into the New Year.

Q. It is right, yes. And at that time, my understanding from your witness statements and this is from your and

your legal team's analysis, down, her diagnosis at that time was given as moderate to severe agitated depression?

A. DAWN: Yes.

Q. Thereafter, at the end of January, your mother was discharged to the care of the community mental health team.

A. DAWN: That's correct.

Q. And my understanding is that across the sort of early part of 2008 and the Spring, a range of different medications were tried to deal principally with her anxiety.

A. DAWN: That's correct.

Q. She had home visits, I think, from a community psychiatric nurse.

A. DAWN: Yes.

Q. And continued to see a psychiatrist within the community mental health team during that period, is that right?

A. DAWN: I can't remember the order that they came in. I can only remember when we had to actually call the crisis team out for an emergency psychiatrist.

Q. Yes. By July, I understand that the records show that she was very much better.

A. DAWN: That's correct, yes.

Q. And Craig, the way you describe that is that you felt that by that stage you had your mum back.

A. CRAIG: Yes, to go back to when the crisis team first came out, mum was in serious distress. It was not a pleasant sight, to be fair. The psychiatrist that arrived that day just gathered up all the medication that mum had at that time, put it in a bag, took it away and prescribed this new, these new doses, this new variant of medication. Yes, just to elaborate by July mum was back and very much herself, a big change.

Q. The psychiatrist then decided she was so well by then that a plan was made to, over the next three months, to wean her off any antidepressants and I think that had happened by 1 October 2008.

A. DAWN: Yes so that she didn't become dependent on anything because she was back to her normal self.

Q. And, in fact, she was discharged then back from the Community Mental Health Team on 1 October 2008?

A. DAWN: I can't remember the date, but certainly, yes, in the autumn.

Q. In summary, as a course of treatment, what was done over that period, when you first noticed or your wife first notice those symptoms or the feeling that something was off, your mum wasn't right, to 1 October 2008 that course of treatment and intervention was successful?

A. DAWN: Very.

Q. Thereafter she was well, and I understand that in 2011

there was a very short period, towards the end of 2011, when your mum started to suffer again with poor sleep.

A. DAWN: Yes.

Q. Which had been a trigger back in 2007?

A. DAWN: Yes.

Q. But that her poor sleep did not, on that occasion, turn into anything else because she was prescribed, I think, diazepam and zopiclone to get her back into a regular pattern of sleep and those drugs were stopped by the end of 2011 and then she remained well.

A. DAWN: Yes, it was just a very quick spike as such.

A. CRAIG: Could I also add.

Q. Please do.

A. CRAIG: At the end of when mum was feeling well, she was clearly and very willing to articulate what caused that issue, anxiety spout, which we then were able to address and reassure her. So you know, the fact that that treatment was successful and it addressed those issues and those symptoms, it was a win-win in every case that the issues were addressed and we obviously got mum back to, well to her best.

Q. I understand, and I think you will correct me if I am wrong, it is both of your feeling that the reason that was successful is because her presenting symptoms which were very high, unmanageable levels of anxiety, were

first dealt with and then you were able to begin to understand what had caused the anxiety and to address that such that she became settled and well.

A. CRAIG: That's correct, yes.

Q. If we come to early 2013, her anxiety began to return?

A. DAWN: Yes.

Q. I think you tell us there were a number of triggers for that, your brother was experiencing some personal problems, your father was unwell. She had had some dental problems that were affecting her sleep. That in itself being a trigger for the return of anxiety. And Dawn, I think you note that by 2013 you and your siblings were all busy with your lives and your own families, and your mother was the doer in the family and possibly felt some sense of loss, is that right?

A. DAWN: I think obviously it got to the stage that Craig's children, obviously my sons and my other brother's daughters, they were all old enough doing their own thing, so they didn't much -- not need, they obviously did their need their nan. But they didn't want to be there with them all the time and they were obviously off doing things by themselves. So yes, that's where mum felt the loss that she wasn't as involved as she wanted to be.

A. CRAIG: I think as parents, with all due respect to my

mum and dad at the time, we didn't need their help as much because the children were able to look after themselves. So we didn't need the babysitters, which is something that mum loved to do and obviously she was missing.

Q. And then the children didn't need babysitters?

A. CRAIG: No.

Q. Understood. In the spring of 2013 Iris was first seen by her GP, who I understand -- and you have set out some of the medications, Dawn, in your witness statement, prescribed really a range of different medications across the Spring and the summer.

A. DAWN: Yes. That was gleaned from obviously mum's medical report which our legal team has set out for us.

Q. Yes, I understand. By April 2013 there had been a referral to the Community Mental Health Team.

A. DAWN: Yes.

Q. And then by June I think efforts had been to adjust or reduce some of your mum's medications, but the GP noted that doing so had worsened her condition quite significantly?

A. CRAIG: Yes.

Q. If we can look, please, Dawn, at page 5 of your witness statement, I just want to ask a couple of things about the notes you have here. So we can see that what you

have -- what is recorded are some of the changes to your mother's medication between 26 June 2013 --

A. DAWN: Yes.

Q. -- and her date of admission to Ruby Ward, which was 23 August 2013. But to make clear, I think you have just said it actually, but these are not complete records. This is not a cut and paste.

A. DAWN: No. No, this is just a summary and it just really highlights how many different changes of medication that mum actually had.

Q. Yes. And looking at that, if you could look, please, at page 6 and at one of your entries, the second entry on 24 July 2013, we can see some of this. There appears to be an effort just to stabilise your mother. The wording used there is:

"I have reinstituted some of the medication in a hope that it might help put her back on an even keel for the time being."

A. DAWN: Yes.

Q. We then also see, there are notes here about her questions about her medication, I think.

A. DAWN: She always questioned her medication, and I think if I can go back to on that occasion where we took mum to the Priory, the psychiatrist there was very quick to say that, "You need to stay on a medication for at least six

weeks for it to take a hold", but also, on the flipside of that, not stay on it so long so you become dependent. I think mum was frustrated because, she wanted to be well and she was very quick to ask for medication to be changed so that she could be well.

Q. She was quite vocal about that?

A. DAWN: Yes, definitely.

Q. And I think part of your consideration is that something had worked for her in the past during the 2007/2008 period, so she knew a balance could be struck and she wanted it to be achieved?

A. DAWN: Yes, that's what we asked for but that wasn't happening unfortunately.

Q. So she had no anxiety in general around taking medication, she was just pushing for the right balance to be found? I understand.

A. DAWN: Yes, because back in 2008 the medication that the crisis psychiatrist gave her actually knocked her out, which was not nice to see, for I would say probably about three days, that's right, Craig? But then it kind of reset the clock. She was just spiralling between different medications.

Q. Yes, understood. You both note that at the time, before the summer of 2013 and before Iris was admitted to Ruby Ward, the particular psychiatrist who was treating her

appeared to change her medication according to her request, rather than at that psychiatrist's own direction. You both tell us that your mother was a strong character and that psychiatrist appeared to be being led by your mother?

A. DAWN: He was totally led by mum and always changed the medication when she requested it.

Q. Was that something that concerned both of you at the time and that you noticed at the time?

A. DAWN: We noticed it at the time, but at that stage this was probably our first interaction on a regular basis with somebody and we just thought, we didn't query it at that stage, we thought it was the process and we thought they knew what they were doing.

Q. Yes. I think at a later stage, because that particular psychiatrist, in fact, continued his care of your mother into the early part of her admission into Ruby Ward --

A. DAWN: Yes.

Q. -- and stayed until the very end of November 2013.

A. DAWN: Yes.

Q. Dawn, I think you recall, at that later stage, so November 2013, the ward manager in discussing the fact that that psychiatrist was to be reallocated, and your mother was to have a new psychiatrist made comments to the effect of that the ward manager was glad that was

taking place and described that particular psychiatrist as "a bit of a ditherer"?

A. DAWN: Yes, she did, she actually said those words which at the time we both thought was quite unprofessional really to say something about a psychiatrist who was attached to her ward.

Q. Craig, we don't need to go to it, I don't think, but in your witness statement you tell us that it appeared to you, at that time, that what was happening was -- you haven't used this word, but I get the impression from your witness statement that you felt that it was haphazard and that a series of different medications was being tried just to try and find something that might work.

A. CRAIG: Yes, and it was also hinted or implied that there are many different medications we can try, it was a matter of finding the right one. It was almost an excuse for the forever changing medication.

Q. Looking at your statement, the words that you recall are that the psychiatrist said:

"There are lots of different drugs we can try, we will find the right ones eventually."

A. Yes, which didn't quite sit right with me, to be fair, especially obviously after having the experience we did in 2007/2008.

Q. By 30 August the decision was taken that Iris should be admitted as a voluntary patient to Ruby Ward at the Crystal Centre. Can you help us with what you can remember, and I appreciate that it was now more than 10 years ago, about the basis for that decision. Why was it decided that it would be best, by then, for her to be admitted as an in-patient?

A. DAWN: To take mum out of the family situation for what they suggested was just going to be a three-week quick fix.

A. CRAIG: And also dad's health. He was struggling and dad couldn't cope and we couldn't be at their home 24/7. It wasn't a good situation, you know, dad had obviously, being a bit older than mum, was struggling and still not in the best of health. He wasn't unhealthy, but not the best of health and he was struggling to cope with mum's anxiety especially at those elevated levels.

Q. Understood. So who was it that told you that the plan at that stage was for her to be admitted for a three-week period, do you know?

A. DAWN: I believe it was the psychiatrist that mum was under for that period up until November. I think it was him that suggested that this would be the way forward.

Q. Effectively to take her out of the home situation, your father for obvious reasons was struggling to care for

her, stabilise her perhaps and she could go home.

A. DAWN: Yes, as a voluntary patient.

Q. As a voluntary patient. As we know that is not what occurred.

A. DAWN: No.

Q. And your mother remained on Ruby Ward until she died on 1 March 2014. Before we go through, I would like to take you through what did occur on that ward between 30 August 2013 and your mother's death in March 2014. I want to take you through a summary of what you consider to be the most key issues and the most grave failings, so that we see as we are going through that more detailed chronology, those listening understand what it is that we are looking at and the context of what happened here. If at any time I make an error or there is something you want to add, please say so. I think knowing that Iris was on the ward between 30 August 2013 and 1 March 2014, one of the key issues you have raised is that at no stage during that time did there appear to be a clear or settled diagnosis?

A. DAWN: No.

A. CRAIG: Correct.

Q. In fact, and we will come to see it, questions were being raised I think as late as late February 2014 as to whether or not there was any mental illness and whether

the matters might be related to personality issues, is how they are described, or a personality disorder.

A. DAWN: That was probably 36 hours before mum died.

Q. Yes, and in fact I think what you are referring to is a psychologist's report that was -- yes, 28 February is the date on the report, but I think perhaps he saw your mother on the 26th. That report concludes that there is no depression, but notes that there is an increased level of anxiety beyond what we might expect in everyday life.

A. DAWN: That's correct.

Q. In other words, unless you think I am summarising wrongly, a mild anxiety.

A. DAWN: Yes.

Q. And that report is dated the day before your mother died. There are also some very grave issues around treatment, care planning and medication. We have talked about it a little and we will come to it again. I think is this fair, both of you had the impression and remain of the impression that what staff were attempting to do was to find and treat the underlying cause for your mother's symptoms rather than dealing with the symptoms themselves?

A. CRAIG: Yes, in one of the meetings, I'm sure when we spoke to the psychiatrist, we directly asked that question and that was the answer we got.

Q. And your feelings on that were?

A. CRAIG: Well, it seemed to be a cart before the horse scenario, especially after experiencing what we did in 2007, 2008 and also a very close friend, who is part of the industry, a clinical psychologist in Australia and he happened to be over in the UK at the time and we just asked him, I just remember running that scenario past him, and he said, "That's definitely the wrong way", or in his expert opinion it would be the wrong way to treat a patient in such condition.

Q. In that he would have preferred to see the presenting symptoms, and the principal presenting symptom I think was this unmanageable anxiety, treated and dealt with and then some headway being made into what the underlying issue might be.

A. CRAIG: That's correct.

Q. But what you say over the whole of that period of her admission, is this right, is that that was the other way round?

A. CRAIG: Exactly.

Q. I don't think there was any real care plan that you felt you could follow or that she could follow?

A. DAWN: No, I think she was very frustrated by that.

Q. Yes. That frustration and that lack of structure heightened her anxiety?

A. Definitely, I mean she was in a ward that she shouldn't have been on. It was, I think at that stage possibly above 80 per cent of the patients unfortunately had dementia, but mum, apart from her illness, was very switched on and wanted to engage. She needed to be occupied all the time and she really felt alone because she really couldn't have much conversation.

Q. I think we will come to it but one of the senior nursing staff, in her witness statement for your mother's inquest, explained that unfortunately at that time it was the case that there were a large number of dementia patients on Ruby Ward and that was something that caused a great deal of upset to some of the ward's more functional clients, that's the way in which she has described it.

A. **DAWN:** Yes.

Q. In particular to your mum, who was active, sociable, needed some stimulation and contact and actually ended up being very isolated.

A. **DAWN:** Yes.

Q. You describe the ward environment, Craig, as clean but not fit for purpose otherwise.

A. **CRAIG:** Yes, I mean, it's exactly what you would expect to see on a modern day ward, but as far as fit for purpose, staffing levels weren't great. You could see

that there seemed to be a lot of junior staff members, very much driven from one central point, it seemed to be very matriarchal, one person in charge and everybody followed that individual's direction.

Q. Was that individual the ward manager?

A. Yes, it was.

Q. Thank you.

A. And I would suggest they stayed in line with that direction.

Q. I see.

A. But overall, no, it wasn't fit for purpose for someone of mum's situation. Playing devil's advocate, I'm not sure where else mum could have gone at that time in defence, the NHS or the Trust as a whole, but the care plan, the care was just completely inadequate at that time for a patient of that stature.

Q. Did you ask them about moving ward?

A. **CRAIG:** Yeah.

Q. Did you say to them that this wasn't the right place?

A. **CRAIG:** The only other option was to go to Topaz, which is deemed for younger patients and, although mum was a young 73 year old, very sort of dynamic and sharp, that would have been -- that was deemed inappropriate for her because of the levels of violence and that was clearly detailed to us. So that ward had a problem.

Q. So Ruby was the least worst option?

A. CRAIG: Yes, it seemed to be more sedate.

Q. I understand. In terms of staffing arrangement, you both noted very, very low levels of staff.

A. DAWN: Yes.

A. CRAIG: Yes.

Q. A lot of bank staff.

A. DAWN: Correct.

Q. And an incident you mentioned Craig is one where all members of staff on the ward but one had to attend, I think, the other ward which was Topaz, for an incident, leaving one staff member for 15 vulnerable patients at that time on Ruby Ward?

A. CRAIG: Yes, and there was also another instance where there was one gentleman helping a patient to their room and I actually said -- my words along the lines were, "I bet you are doing this all the time." His direct response to me was and I almost quote, "I'm a patient, mate, I don't work here." That just took my breath away a little bit, stepped back and went "Oh well." And then you look around and it's an isolated ward. A number of patients sitting there at their desks or at these tables in the common room, less than engaged.

Q. Yes. I think you both saw patients helping other patients off the floor?

A. CRAIG: Yes.

Q. Or patients helping other patients to do basic things?

A. Yes.

Q. Craig, you also describe a staffing system that what you saw it was broken and that there were very, very few staff who were actually confident in their roles.

A. CRAIG: Yes, it seemed to be in the short period of the time mum was there, relatively, you know, I'm mindful and I understand that staffing levels can progress and people can get trained up, et cetera, but I'm not quite sure how you go from in one example serving a cup of coffee from behind the --

A. DAWN: Cafeteria.

A. CRAIG: Cafeteria centre which was directly on the ward, to then effectively administering medication in a relatively short period of time. I would have expected more supervisory guidance and one for one tuition. We didn't see that.

Q. Understood. Yes, it seemed to you then that fairly few members of staff were carrying out varied different roles on the ward.

A. CRAIG: I would put it slightly different, that the levels of experience to do the job appropriately was questionable.

Q. Yes. There appeared to you both, I think, to be a

complete lack of continuity in your mother's care and treatment, in that I think during that period she was treated by three different psychiatrists?

A. DAWN: That's correct, yes.

Q. There came a period in very late 2013, going into early January 2014 when there was no psychiatrist in charge of her care, as far as you understand it.

A. DAWN: Yes, there was a period over the Christmas, I think, the psychiatrist that had been in charge of mum just prior to that, either was on maternity leave or sick leave and so there was nobody stepping in or to take the lady's place.

Q. Yes. You had different psychiatrists forming different opinions and your overall sense, I think, was that nobody had an overview or a plan for her care and treatment?

A. DAWN: No, we would have expected, like with the handover or during that period, especially as we had flagged to them like weeks before that Christmas was mum's favourite time of the year and that whatever medication she was on, she would dip because she just wanted to be with her family.

Q. Yes, you told us in your commemorative account about the fact that Christmas was her very favourite time of the year.

A. DAWN: Yes, yes, and to leave her by herself then --

Q. Yes.

A. DAWN: I mean -- but I don't know, they didn't seem to have the forethought to say, "Right, we have got to get a grip of this." They didn't listen, basically.

Q. Yes. One of the things that the serious incident report noted and we will come to that a little later and I am keenly aware that you both see a great number of deficiencies in that report as a whole, but one of the things that it noted was that your mother's key worker appeared to have very little involvement in her care.

A. DAWN: No, not at all, I mean she just she didn't engage with us. She didn't engage with mum. The only time she did engage with us, which we both found strange, was after mum's significant attempt in the January and it was almost like she was trying to make up for mistakes made.

Q. Yes, that was on 14 January.

A. DAWN: That's correct.

Q. We will come to that. In relation to that individual, the SI panel found that she had undertaken no risk assessments in relation to your mother and that there was no evidence that she had evaluated any of your mother's care plans.

A. DAWN: That's correct.

Q. In terms of staff, the way in which staff conducted themselves on the ward, we have talked about that a

little, but it would be fair for me to say, I think, that neither of you considered that ward to be a therapeutic environment.

A. CRAIG: No.

A. DAWN: Absolutely not, no.

Q. Thank you. There was a distinct lack of warmth from staff both towards you as a family and to your mum in particular after her attempt to end her life on 14 January.

A. DAWN: Correct.

A. CRAIG: Yes, I would slightly elaborate on that.

Q. Please do.

A. CRAIG: One of mum's and dad's friends, let's just say he had had a checkered past, he had spent some time in Her Majesty's Service and he actually said the staff there were more considerate and had more empathy than he witnessed on mum's ward.

Q. Yes. We are going to come to some examples of what you described not just as unkindness, but mistreatment from staff towards your mother and there was a failure on more than one occasion to notify you of the very most serious incidents.

A. DAWN: Yes, they clearly went out of their way to try to prevent us going into the ward on the January incident so that, you know, so that we wouldn't see mum's injuries.

Q. Yes. A lack of candour and openness.

A. DAWN: Yes.

Q. And then you describe staff engagement with you as a one way street and that it only occurred if it was initiated by you. Nobody came to you to discuss any aspect of your mother or her care and treatment, is that fair?

A. DAWN: No, they saw us as interfering, I think.

A. CRAIG: Yeah, ultimately, with mum challenging them daily and then when we arrived, us asking the questions, we were clearly the problem family.

Q. Thank you. And then most obviously, you raise grave concerns around safety, the most basic failures to keep your mother safe from harming herself.

A. DAWN: Yes.

A. CRAIG: Yes.

Q. As well as some security incidents, her seeming to be allowed to leave the ward without anyone asking very many questions. I am aware that she was a voluntary patient, but nobody taking note in particular of where she was going.

A. DAWN: Or how long or when she was back.

A. CRAIG: Even though she was a voluntary patient, there were still various restrictions and understandably rules within the ward that she had to abide by, and for them to have effectively a double locked door -- a corridor /door

process to get out and you needed to be tagged in and tagged out. You know, there was again, clear lack of oversight of what mum's movements were at times.

Q. Yes. Your mum also had periods of leave both with you, I think, and with her care worker.

A. DAWN: That's correct, yes.

Q. And I think there were occasions on which she tried to get out of the car when her care worker was driving.

A. DAWN: Yes.

Q. There was a day on which you called to speak to your mother and were told that she was off the ward.

A. DAWN: Yes.

Q. Following her admission on 30 August 2013, I think you know now from the records that throughout September and October she was on level 1 or general observations; is that right?

A. DAWN: Yes.

A. CRAIG: That's right.

Q. We have spoken a little about the ward environment. What you noticed, I think, immediately is that she was spending a great deal of her time alone.

A. CRAIG: Yes.

Q. There were some activities on the ward, I think, but none that were really suitable for her; is that right?

A. Yes, I mean, obviously, there was puzzles and she could

go to Tai Chi and things like that, but again because of the ability of the other people in the group, mum just got frustrated and that then, I think, there was an occasion where she was actually asked not to go to -- well, they stopped her going, because through frustration I think she was disruptive, because she just was desperate for engagement, people to listen to her and to get some care.

Q. And to engage with her?

A. DAWN: Yes, definitely, yes. That's what they needed to do to set up the proper care plan.

Q. Yes. I think on 17 September staff noted that your mother volunteered when asked that she was isolated, there was no one for her to engage with and that she was very, very flat in mood and that was after only two weeks on the ward. Thinking about what one of the senior nurses had said at the inquest about the fact that for those clients on the ward, like your mother, who had much higher levels of functionality than some of the dementia patients, I understand that there was an incident on 23 October 2013 when another patient went into your mother's room, opened his bowels on the bed and punched her; is that right?

A. DAWN: We didn't know about this until our legal team actually looked at the notes, we hadn't been informed of

this at all. And taking you back, Rachel, to where you mentioned about at the end of September mum felt low.

Q. Yes.

A. DAWN: You've got to remember mum initially went in there for a three week quick fix.

Q. Yes, yes.

A. DAWN: And nothing was being done, to sort of comply with that, and that she would be in and out in three weeks. Where two, three weeks in she is telling them she's low and nothing is happening.

Q. Yes. You had seen absolutely no progress and I'm aware that you have only learnt now about the incident I have just described, but it can be very clear to us why in fact that environment might have been making that first presenting anxiety very, very much worse.

A. DAWN: Yes.

A. CRAIG: I think, again, just to add to the point, that we weren't informed on that point. There were other items that we weren't informed on. It just makes me wonder what else happened there that we don't know, that wasn't documented.

Q. Yes.

A. CRAIG: Just complete failure. And it goes back to that lack of engagement. Being willing to -- the accountability or the lack of accountability from the

ward side and the respect for the patient and/or the family.

Q. Yes. The day after that incident, in fact, Dawn, I think you had a call with your mother, you were on your way to Cornwall and she said to you on the phone that she didn't want to be alive and that she wouldn't be here when you got back from Cornwall.

A. That's correct, yes, that was on the 24th.

Q. So that was the day after the incident I have just described.

A. **DAWN:** Yes.

Q. She didn't tell you about that incident.

A. **DAWN:** No.

Q. Was that the first time she had mentioned something like that to you or spoken to you about wanting to end her life?

A. **DAWN:** I'm not exactly sure on timing, I think it was just before then when I went into mum's room I noticed that the toilet seat was loose and the curtain rail and I pointed this out to staff and asked for mum to be moved rooms, which they did comply with, they moved rooms. They were very vocal about the fact that they were anti-ligature beds and the radiators were on the ceiling, but there's door handles everywhere. So they had moved her but they weren't addressing all the issues and

obviously then, with mum making that statement on 24 October, that was in her mind from the early part of her admission.

Q. Yes. Had it been before her admission, do you know?

A. DAWN: No. Certainly didn't know, and certainly dad didn't mention anything like that to us at all.

A. CRAIG: No.

Q. We will come back to it, but you having pointed out those deficiencies, she was moved rooms and you talk about safety issues and radiators on the ceiling, but as we will see, there were fixed ligature points in the bathrooms.

A. That's correct.

Q. After your mother told you that she was feeling that low, and she was quite specific I think, on 24 October.

A. DAWN: Yes.

Q. You obviously, feeling serious alarm, contacted the ward manager.

A. DAWN: I did.

Q. I want to take you to your witness statement, please, to look at, it's page 18, Dawn, the response you got when you reported your mother's low state. So if you look at page 18 and paragraph 65.

A. DAWN: Yes, that's right, yes.

Q. Do you recall that conversation?

A. DAWN: Yes, I recall that without looking at that.

Q. I understand.

A. DAWN: She just said that I was being a paranoid daughter and that nothing was going to happen on that ward and that mum was just trying to raise my anxiety.

Q. Yes.

A. DAWN: And totally dismissive, didn't take anything on board at all.

Q. I think she went so far as to say that if you didn't calm down, you would end up on the ward as well, didn't she?

A. DAWN: That's correct, yes. Obviously, I was very distressed because I'm away and --

Q. Of course. As far as you are aware, there is no record of your call to the ward manager about that --

A. DAWN: No.

Q. -- at that time on that day.

A. DAWN: No.

Q. As far as you were aware, no other action was taken in relation to the information.

A. DAWN: Certainly I have no knowledge of anyone speaking to mum or, as you say, notes making in her records.

Q. The records show no change to the level of observations after you had passed on that information, or any other renewed risk assessment or action of any kind.

A. DAWN: No, no action at all.

Q. The first record that we see of your mother having expressed on the 24th a wish to die comes eleven days later, on 4 November. It's actually at the next paragraph on the page we were looking at, page 18 and paragraph 66. There's a record we see on NEPT's systems from 4 November:

"'... [Iris'] daughter said her mother voiced a concern that she would 'end it all' in a phone conversation - no specific plan was said'."

A. DAWN: That's correct, yes.

Q. On the same day it appears that your mother was spoken to about having told you that she was feeling low enough to want to end her life and just looking at the next paragraphs on that page --

A. DAWN: 67, yes, I am with that, yes.

Q. So 67 on page 18, what happened essentially was that your mother said, "No, I wouldn't want to distress my family, I'm not going to hurt myself."

A. DAWN: Yes, she said she wasn't brave enough to do it, yes.

Q. She said she wasn't brave enough, and as far as you are aware, that was taken at face value.

A. DAWN: Yes.

Q. Moving forward, just four days later, there's a record that shows us that on 8 November Iris herself told staff

that she wanted to kill herself.

A. DAWN: Yes, we weren't informed of that either.

Q. No notification to you either, Craig, about that, or to your father?

A. CRAIG: Not at all.

Q. On that day the psychiatrist seems to have noted "high anxiety depression".

A. DAWN: Correct.

Q. And then on the next day, which is 9 November -- no, I am so sorry, 9 November is when that was discussed with her on the ward round, no other action was taken although I think there was that day a CPA meeting that you attended. You tell us that at paragraph 69?

A. DAWN: Yes. As I say I think that perhaps we were asking for a CPA meeting --

Q. I understand.

A. DAWN: -- because nothing was happening and we were just trying to get some action and ...

Q. So were you told during that CPA meeting, as far as you can remember, that on 8 November Iris had told staff that she wanted to kill herself?

A. DAWN: No, I didn't recall that at all and until we were speaking to the legal team after we were doing our statement, yes.

Q. That's when you first discovered --

A. DAWN: That's when we first discovered that mum had made a couple of comments that she was low enough to think about wanting to take her life.

Q. Yes. It appears then, going through November, that a number of further changes appear to have been made to your mother's medication and that by 18 November the psychiatrist who was taking over from the one that had been described as a bit of a ditherer, that we were discussing earlier, noted that she considered that your mother's diagnosis was still unclear.

A. DAWN: Yes.

Q. So that's mid-November and so we are a number of months in to what should have been a three week quick fix, sort of respite stabilise stay.

A. CRAIG: Yes, again, you know, not meaning to be defending the Trust but mental health isn't a science. It seems that from our experience it's very subjective.

Q. Yes.

A. CRAIG: And it just seemed that this particular psychiatrist now had a completely different view as to where mum should be treated, and I think from the lack of progress that we had seen in mum under the original psychiatrist, the fact that this particular individual wanted to change it, we were thinking okay maybe he has got it wrong and she is going to get it right. For a

family that had not been through that process before, it was difficult to understand what was the right approach, but that underlying treatment plan just seemed to be very much the same of treating -- not treating the symptoms, and it was just following that same path.

Q. Yes. Nonetheless, as you say, the fact that there appeared to be a -- the fact that there was a new psychiatrist and a slightly different opinion, you took as a potential positive, because no progress had been being made up to that point.

A. CRAIG: We just thought it couldn't get any worse.

Q. Yes. In December, and I think this comes to us from the serious incident report, the psychiatrist noted that -- it's actually at page 19, paragraph 71, Dawn -- both of you, I am so sorry, if you want to look it:

"... that 'while depressive illness played a part, personality issues were more important'."

Now that's not the first time we are going to see that kind of comment in your mum's records. Did anyone ever say anything like that to you, any staff member, did anyone say, "We think this might be personality issues rather than, or as well as, a depressive illness"?

A. CRAIG: No.

A. DAWN: No. I think in the December they talked about

doing a scan.

Q. Yes.

A. DAWN: Because they thought that there may be some small nerve damage, frontal lobe damage. That was early in December, but again, we didn't get the results of that until 23 January, when we challenged in a CPA meeting.

Q. Yes, so that's -- yes, we will come to that CPA meeting which was on 23 January, but I think that's right and in fact the new psychiatrist on 3 December had noted that actually, in her view, your mother was not responsive to medication. It just wasn't --

A. DAWN: Wasn't working, no.

Q. It wasn't working, which of course is what your mother had been saying for all of those months --

A. DAWN: Yes.

Q. -- repeatedly. She felt it herself that it wasn't working, she wasn't making any progress. I understand that a referral was made for a scan to begin to look at the possibility of the issues you have just described on the 17th -- actually on the 3rd. It took place on 17 December and then you repeatedly chased for the results of that scan.

A. DAWN: Yes.

Q. You left messages?

A. DAWN: Yes, I think the psychiatrist, she was quite

surprised that we hadn't had the results by the time that we were challenging the staff on 23 January.

Q. Yes. Do you know what the results of that scan were?

A. DAWN: I think there was -- I can't recall exactly, but I think there was small nerve damage, maybe? But again, I would have to look at mum's notes to be 100 per cent sure on medical terminology.

Q. No major issue was flagged as a result of that scan?

A. DAWN: No, definitely not.

A. CRAIG: Nothing that would change their path --

A. DAWN: Change their path.

A. CRAIG: -- or suggest that the treatment -- treatment plan -- it would completely deviate from where they were going at that moment in time. So mum was in all sense healthy.

Q. Yes, we have referred to this a little already, but your mum remained on the ward in the lead-up to Christmas, you were see no progress and I think you took the step of trying to warn staff that she was likely to deteriorate over the Christmas period.

A. DAWN: Yes, we did warn staff.

A. CRAIG: More than once, repeatedly, because again we never felt we were being listened to especially round this time of year. We knew how mum was going to be reacting away from her family.

Q. Yes. I think at that time you were worried about changes to staff as well as how she was likely to react, as you say, to being away from home over that particular period.

A. CRAIG: Yes.

Q. There came an incident on 19 December where, as I understand it, your mother left the ward and there was some sort of incident in the car park where -- did she run at your father's car?

A. DAWN: Yes. Dad and I had gone to the hospital independently, we were in the car park, and mum had obviously been let out of the ward, as she had a coat on, but she sort of run towards, like dad's car, and she was telling him to go, go away, and she was quite vocal and she looked very agitated, but obviously they had let her out of the ward like that.

Q. Yes. That event, as I understand it, from both of your witness statements and from the records that you have relied on in those statements, led to a decision in the ward that your mother should be assessed under the Mental Health Act?

A. DAWN: That's correct, yes.

Q. Help me to understand why that was. Was that because she had displayed particular agitation outside of the norm, was there some danger or some new level of --

A. DAWN: I think because she had run out into the car park,

she had been let out in an agitated state and again, it was obviously because she was going to be there at Christmas, nothing was happening and this was her desperation.

THE CHAIR: Was she aggressive when she was agitated?

A. DAWN: Not aggressive, she was more vocal, she was just telling them to go. I think, I mean she was frail, you know, so she wasn't going to -- my dad was 6 foot, although he was elderly, he was 6 foot 3, she was barely 5 foot, so there was nothing she could do. She was just frustrated with there being no action and unfortunately on that day it was directed towards our dad.

A. CRAIG: And I wonder whether the decision for the ward/hospital/trust to section mum at that time was more for their benefit than it was for mum's, granting them more direct control and oversight over her movements, et cetera, where as an in-patient under the --

Q. As a voluntary --

A. CRAIG: She can move relatively freely. Where, obviously, if you are sectioned, they have greater responsibility, perhaps, to your care, which they can then enforce. So I wonder whether it's more for their own controls than it was for mum's wellbeing.

A. DAWN: I also question the fact whether it was not to punish us, but again, sort of put us in our place, that

over that period she is going to be on section because around that time they actually restricted visits as well.

Q. So you tell me if I am misunderstanding. Do you consider that there may be an element of, not just what Craig said about having control over your mum's movements, but also in fact over yours?

A. DAWN: Their way of containing the situation.

A. CRAIG: Indirectly punishing us all.

THE CHAIR: You said earlier that they though you as the problem family. Do you want to say a bit more about that?

A. DAWN: Well purely because --

THE CHAIR: Were there individuals or did you think all of them felt that?

A. DAWN: Every day we had an issue to raise because we wasn't getting any feedback, the staff didn't have time to talk to us. As we have mentioned before sometimes the periods we were there we would only see one permanent member of staff, the rest maybe at a desk, every time we approached that desk shoulders went down and it was, "Like, what do they want today?"

A. CRAIG: The tone was set from the top, as I implied earlier, from the people in charge to ward manager, and the people reporting in to her. She controlled that ward. I wouldn't say with a rod of iron, but you knew --

THE CHAIR: Sorry, could you repeat that?

A. CRAIG: I won't say she controlled with a rod of iron, but she was very, very clear who was in charge and how the ward would be managed and run. And if that person, that individual, took a decision, everybody jumped. I am sure we are going to touch on a bit later, when we talk about the first attempt, so I'll probably just leave it there for a minute.

MS TROUP: I think there was a stage after that where, in particular, Dawn, you had a conversation with a staff manager who told you that you were not complying as a family.

A. DAWN: Yes.

Q. And that you were not assisting your mother by not doing so.

A. DAWN: That's correct and we were making the situation worse and because of our presence on the ward, they had to deal with mum in a different way.

Q. Yes.

A. DAWN: I remember leaving the hospital that day, and when I got home my husband suggested going back to speak to the staff and try and address the situation while it was still fresh, but we had then, by things that mum had said and by the things that she had written down, that -- because she used to say, "You can't beat the system, you

don't realise what they are like when you're not here." We thought that anything we done, we were not -- we didn't ... it wasn't we thought she was in danger, but there certainly was not, we didn't feel comfortable about the situation and it was from that day that I decided that I was going to start making a personal diary of every time, a note in the diary, every time I went in there what had happened and asked mum to do the same.

THE CHAIR: And did you get the impression that they were hostile, not just to you as family, but to your mother personally?

A. DAWN: Yes.

THE CHAIR: That they didn't like her?

A. DAWN: No.

A. CRAIG: They didn't like to be challenged, and the fact that, as Dawn just implied there, if we then challenged again and again, that would -- when we left the ward that would only be taken out on mum, whether it would be leaving her on her own for long periods of time, just making her life generally more difficult. It was becoming anti-productive from our challenge to what might then, we were hoping would, where mum would benefit, in fact, it was I think the opposite effect.

MS TROUP: Yes. There came to be a stage, I think, where both recorded in your mother's diary and in what she said

to you, it appeared to you, I think that she was afraid.

A. DAWN: She was afraid, yes.

Q. Yes, and we will come to some of the reasons for why that might have been, but she recorded in her own thoughts in that diary and said to you, "They'll try to break me."

A. DAWN: Yes.

Q. And she was worried about repercussions?

A. DAWN: Yes, she always used to write notes in there, "Be careful what you say to them." And that was, "Be careful what you say because it comes back on me."

Q. Yes, and also things to the effect of, "You don't know what it's like in here when you are not here." Craig, you must help me, do I understand correctly that that is something that you heard another patient saying?

A. CRAIG: Those exact words, we were sitting in the common area, so the four, the family -- I'm not sure if it was through another incident or we were just sitting there passively talking to mum, but there was another lady sitting with her family and those exact words she repeated.

Q. What were the words, please?

A. CRAIG: "You don't know wait's like in here." Prior to that, I have to say when mum said it, I probably didn't take it as serious as I should have, or we should have, not in the same context, because clearly we didn't know

what it was like to be in a ward like that for that period of time. But that just struck me as very ... I don't know the word, poignant.

A. DAWN: Telling.

A. CRAIG: Telling.

A. DAWN: Because around that time as well there was a similar situation, where we were sitting on those tables, I'm not sure if it was the CQC that were in. There was certainly a body of people going around asking questions.

Q. An inspection, was it a formal inspection?

A. DAWN: Yes, a formal inspection of some sort, because mum was, I was looking to try and get someone's attention and she was agitated, "No don't rock the boat, just leave it, let it go."

Q. She didn't want you to complain.

A. DAWN: No.

Q. You said a few moments ago in response to some questions from Baroness Lampard about it that you were at the desk every day, there was always something you needed to raise, but I want to just try and set that in context and you tell me if this is wrong. As I understand it, in part that is because the questions you had were never answered so they remained the next day?

A. DAWN: Yes, and we never got to see anybody. Even if we said, "Could you ask so and so if this is, what's going

to happen next", we never got that response back. So we were getting perhaps as frustrated as mum and we could see mum getting worse. You know, nothing was getting better so we had to try to do something. I can't remember if it was around that time that we actually made enquiries at the Priory but it was beyond our reach.

A. CRAIG: Financially just no chance.

A. DAWN: It's not like a broken leg where six weeks or whatever it may be better. We just didn't know how long. We couldn't financially, I'm sad to say.

Q. I understand. Could I take you back please to the assessment that look place following the incident in the car park on 19 December. Did either you or your father attend that assessment?

A. DAWN: Not that I recall, no, we were just told.

Q. That it would be taking place?

A. DAWN: Yes.

Q. Or you were told that it had taken place?

A. DAWN: Probably we were told that she had been placed on section 2, yes.

Q. Now, one of -- if you want to have a look at them, the comments that are recorded by the clinicians during that assessment are on page 20 of your witness statement, Dawn, at paragraphs 79 and 80 and one of the things I wanted to ask you about, we can see here that the records

say, obviously both doctors agreed that your mother should be detained under section 2.

A. DAWN: Yes.

Q. That was the conclusion of the assessment, but her behaviour here is referred to as "becoming very unpredictable", and there's a note that she "constantly questions her medication". But if you look at paragraph 80 the approved mental health practitioner appears to have used the word "aggressive" in relation to your mother's behaviour and all I wanted to ask is whether or not you think -- you may have answered it, but whether you think that's a fair assessment, whether you think that is right that she was actually aggressive.

A. DAWN: I don't think she was very aggressive, like I said she was very vocal, just, "No, no, no, no go way."

A. CRAIG: How do you define "aggressive"?

Q. Let me put it this way, had anyone on the ward ever told either of you that she had behaved in an aggressive manner.

A. CRAIG: The only person, sadly, that mum was aggressive to in any way, shape or form was my dad.

A. DAWN: She would give him a little nudge.

A. CRAIG: Nudge or grab his hands across the table and lurch a little bit towards him. I'm not sure if she may have kicked him under the table, not hard but enough. An

unnecessary act, but she certainly wasn't aggressive to anybody else, not to anybody else in her family and I would suggest that had she been aggressive to anybody else on that ward, staff/patient, they would have told us.

Q. You would have known about it?

A. DAWN: Definitely, yes.

Q. In any event, as I understand it, from certainly your notes, Dawn, in December and January your mother was spending around about 12 hours a day alone?

A. DAWN: Yes, she wasn't allowed into to her room, her room was locked, and she had a tote bag with her I suppose, and she used to sit outside by the nursing station from the moment she got up, she was probably not supervised but probably watched getting dressed. She then had to spend that time in the communal area. Obviously she then had very little stimulation. She wasn't talking to fellow patients and because of her behaviour she hadn't been welcomed at some of the activities outside of the -- within the Crystal Centre, the Amethyst ward. Yes, she hadn't been invited back to perhaps the Tai Chi and things like that.

Q. And part of that was, as you described, she was finding that very frustrating.

A. DAWN: The way was she was presenting, yes.

Q. It was too easy for her, she was frustrated.

A. Yes.

Q. What I understand that you were told about the section on 20 December?

A. **DAWN:** Yes.

Q. And you were told she was going to be sectioned for 28 days as a result of that assessment and you were at the same time told, Dawn, that your visits were going to be restricted?

A. **DAWN:** That's correct.

Q. That was 20 December that was after you had conveyed to staff, I think both of you, that your mother was likely to deteriorate over Christmas.

A. **DAWN:** Yes, and I'm not sure if it was on that day. I think they said, "You've got ten minutes with your mum", and I remember saying to mum, "Right, we have got ten minutes, this is what's going to happen, this is what I want you to do." I used to take her clothes home to be washed, "Give me your clothes and now this is what I want you to do. I want you to write down ..." but she was -- not out of control -- she was seriously agitated because she was now thinking, "I'm in there and not only am I not going to be out of the hospital to be with my family, my family aren't going to be able to come and see me", and she had gone from being lonely to desperate.

THE CHAIR: What reason was given for restricting your visits?

A. DAWN: They said that our visits raised her anxiety, but there was nothing that we could see, and I don't think there's been anything in the notes to say that that -- that we raised her anxiety. Because it wasn't just Craig and I that were going in. Mum had a big circle of friends who were also visiting. So it was everybody, and my mum's sister-in-law was more like her sister really, because my mum had lost her brother at such an early age, and they had a very close bond. It wasn't just us. It was the whole family.

A. CRAIG: I think they saw it as well that we were placating to mum's condition and where they were being firmer, or wanted us to be firmer and we were being sort of more considerate to mum's needs and that was something that they pushed towards myself and, unfortunately, I adhered to their requests and I was firmer to mum. I absolutely regret that to this day.

Q. I understand. Now, that is interesting because what I recall is that on 20 December which was the date of the assessment under the Mental Health Act, your mother recorded in her own diary notes to the effect of, about the staff, "They think I'm putting it on, they think I'm putting this on to attract attention." And what you are

saying, I think, Craig, is possibly that you were not treating this as something your mother was putting on and therefore, possibly, disrupting what staff -- the way in which staff were approaching it, is that fair?

A. CRAIG: Yes, I guess the stance I took, although slightly firmer than perhaps Dawn and dad, I just tried to get her perhaps a bit more forcefully to engage with the programme that the ward was setting out for her rather than fighting it and I think I probably used along the lines of, "There's no point fighting it, you are not going to win. You just got to go with the flow and we are going to come out stronger and better at the end of it." And she just kept repeating, "It's not happening, not happening." That would frustrate me. I was probably less patient and that than I am today.

Q. Thank you. Dawn, I am going to take you, please to the conversation you had with a member of staff on the 22, which will just take us a few minutes and thereafter, as long as you are both content and, Chair, you are content, I propose a short break. You, in fact, were told, I think on the 20th, you did visit -- Dawn, and I am looking please at page 21, paragraph 83 of your statement if this assists. You did visit and a staff member accused you, I think possibly not you personally, your family, of interfering with your mum's progress,

disrupting her and she reiterated that your family as a whole was not complying and not supporting nursing staff.

A. DAWN: That's correct.

Q. She also said that your mother was not eating, drinking or sleeping. Was that true, as far as you were aware?

A. DAWN: No, that was not true. Every day I went in there I brought, she had a cake and a Bounty, she certainly ate the stuff from the canteen. She was losing weight because of her anxiety. Her metabolism was going at the speed of light, you know. That's why she was losing weight.

Q. Yes.

A. CRAIG: The same had happened in 2007, 2008, mum had lost a significant amount of weight purely because her metabolism was obviously through the sky.

Q. Because of that very significant anxiety.

A. DAWN: Yes.

Q. Understood. On the 21st you were told that the ward was closed and that you couldn't visit until the following Monday, the 21st was a Saturday.

A. DAWN: Yes.

Q. You called, I think, Dawn, then on the 22nd, which was the Sunday, and when you called in the morning, you were told that you couldn't speak to your mum because she was too agitated.

A. DAWN: That's correct.

Q. And then you did manage to speak to her later that day, on the 22nd, and she told you that she was frightened.

A. Yes, she was frightened. She was upset, yes.

Q. At some stage on that day and during that visit, staff informed you that you, not you personally Dawn, your family, would not be able to visit over Christmas; is that right?

A. **DAWN:** That's correct.

Q. And obviously you have already made clear that was the worst possible time to be restricting contact. What reason was given?

A. **DAWN:** I can't, I honestly can't remember a reason. It was just that they had made the decision, as Craig had referred to earlier, that perhaps this was their way of dealing with us as a family, mum as a patient, but if they were going to do that, why hadn't they done that in the first couple of weeks and said, "Okay, right, your mum's here, we've got three weeks, let's go from now." We are now into month four.

Q. Yes. I think you have both addressed this really, you considered that it was a punishment of sorts --

A. **DAWN:** Definitely, yes.

Q. -- this restricted contact and it was around that time I think that you decided to instruct an independent

advocate.

A. DAWN: Yes, I don't know, I remember getting a card -- I don't know if that was at the -- I don't know how that all came about because obviously myself I was agitated at that time, I was having to deal with dad who was also agitated, wasn't he, because he just wanted us all home as a family.

A. CRAIG: Just to add to the extra pressures Dawn was experiencing at the time, I was away on holiday.

Q. You were what?

A. CRAIG: I was away on holiday. I had left on the Friday, which would have been the 21st, so Dawn was managing this on here own. A lot of what happened from now from the 21st until the New Year I wasn't aware of. So kindly Dawn kept this from me, so I could enjoy my holiday with the family.

MS TROUP: Thank you.

Chair, would you be content to take a short break there?

THE CHAIR: Ten minutes?

MS TROUP: Yes, please.

(11.28 am)

(Break)

(11.47 am)

THE CHAIR: Ms Troup?

MS TROUP: Before the break we were talking about the fact that just before Christmas, you instructed an independent advocate. Am I right in understanding that the principal purpose of instructing the advocate at that stage was to try to get some access to see your mum over Christmas.

A. DAWN: Correct.

Q. I understand that that advocate went into the ward?

A. DAWN: He did.

Q. And spoke to staff and whatever those discussions were, on Christmas Eve you were told that there had been a U-turn and that you could visit your mum?

A. DAWN: That's correct.

Q. In a call on the same day, I think on the evening of 24 December, Dawn, your mother again expressed to you that she did not wish to be alive.

A. DAWN: Yes

Q. Can you remember whether you reported that comment to staff?

A. DAWN: I can't remember on that occasion, no. Obviously that was at same time we had just been told we could go to see her, and I knew she was anxious that I could see her the next morning, on Christmas Day.

Q. You also tell us that you felt, you had a feeling during that call that your call was being listened to.

A. DAWN: Yes.

Q. Tell us about that, please?

A. DAWN: There was just a click on the line. It wasn't a delay but it just ... I couldn't hear somebody was there but I was aware that with the click, that someone could possibly be there.

Q. And you had that feeling.

A. DAWN: I had that feeling, yes, which I now know was being listened to.

Q. We will come to that because there comes a point in February when in fact NEPT's records show that your mother requested to be allowed to make telephone calls to her family in private without being monitored and that that request was declined.

A. DAWN: Yes.

Q. On Christmas Day, what your mum said to you was that she couldn't stand being a prisoner anymore and that she wanted to kill herself. This is at the last two lines of paragraph 88 on page 22, if you want to follow.

A. DAWN: Yes I'm with you there, yes. Again, she just was saying she felt alone and as always her medication was wrong.

Q. Yes, and she had raised that on Christmas Eve as well, I think, hadn't she?

A. DAWN: Yes, yes.

Q. That her medication was wrong?

A. DAWN: Yes.

Q. I ask again, but I do bear in mind what you have described about the slight bind you were in. Do you remember whether or not you reported that comment on Christmas Day about wanting to die?

A. DAWN: I can't remember 100 per cent. I can't see a reason why I wouldn't have said but I can't truly say unless it was there in my notes to say, there was just so much going on.

Q. Yes, I understand. Moving forward into the New Year, you were told on 2 January that there would be another change of psychiatrist; yes?

A. DAWN: That's correct.

Q. I think you were both unhappy about that -- perhaps Craig you were still away?

A. CRAIG: No, I had returned by that point.

Q. You had returned. You were both unhappy about that because we are now on to the third psychiatrist during this admission and you voiced your frustration about that to the ward manager.

A. DAWN: That's correct, but she still didn't -- there was a gap before, we were told that mum was going to get a psychiatrist but I don't think that happened for perhaps another week, it certainly didn't happen on the 2nd.

Q. I think that's right because what the records show is

that by 7 January, the last time your mum had been seen by a psychiatrist was on 27 December?

A. DAWN: Right.

Q. So there was something of a gap. On 9 January, when you spoke to her on the phone, she was very agitated and told you, I think, that in part that was due to the change of psychiatrist.

A. DAWN: Yes.

Q. She also, Dawn, I think told you on that call that staff were trying to break her down.

A. Yes, she just said staff were lying and that she couldn't carry on and she said trying to break her down.

THE CHAIR: Did you ever have moments when you wondered whether she was delusional? In other words, did you have any reason --

A. DAWN: No --

THE CHAIR: -- to question the truth of what she was saying?

A. DAWN: Absolutely not, no. Absolutely not, no because we also had a feeling that things weren't right as well and she was never one, she didn't exaggerate things. She was just frustrated. The way she presented, obviously she was ill, but that was due to her frustration. She just wanted to be out of there. She wanted to be back doing what she used to be doing.

A. CRAIG: She certainly didn't present any other issues of

delusion with anything else, it was --

THE CHAIR: Truth?

A. CRAIG: No, nothing like that. She was still very much the strong individual that we knew her to be but obviously the topic of the conversation was always around the care, lack of care, the medication. It was always very focused, so to go there and have a, a pleasant meeting, a sort of social meeting with mum, was nigh on impossible, certainly made things hard. But, you know, she was the one that was suffering more than anybody else, though.

THE CHAIR: Thank you.

MS TROUP: On 12 January, I understand again, Dawn, that your mum told you, not only did she tell you again that she didn't want to be alive, but she disclosed to you that she had tried to suffocate herself.

A. DAWN: That's correct.

Q. She had used an item that we might describe as a very everyday item but that was nonetheless obviously risky.

A. DAWN: Yes, and available to her, yes.

Q. Yes. On that occasion, because of the information she had given you, you did inform staff.

A. DAWN: I did.

Q. And as far as you are aware, was any action taken?

A. DAWN: I don't think any notes were made, they certainly

didn't speak to mum whilst I was there.

Q. There's nothing in the records that shows any change or any action?

A. DAWN: No, she just remained on -- I think she was on level 1 then, yes.

Q. She was. And on 13 January the records confirm that she remained on level 1 observation so there had been no step-up --

A. DAWN: No.

Q. -- in those observations as a result of the information you had conveyed to staff.

A. DAWN: No, that's correct.

Q. The following day on 14 January her period of section had come to an end and a decision was taken by clinicians not to extend it. Now I think what you tell us is that you do not remember having any input into that? Am I right that you were simply told that had ended and it wasn't going to be extended?

A. DAWN: Yes, I just think that the period was up and that was it, despite having said -- you know, what mum had said to me on 12 January, two days later they didn't think, "We will extend it for another week."

Q. Yes. As far as you are aware, either of you, was any further assessment taken place -- did any further assessment take place at that stage?

A. CRAIG: Not that I'm aware.

A. DAWN: Not that I'm aware.

Q. And presumably, if you didn't have any input into the decision, or if nobody asked you about your thoughts about whether or not that period of section should be extended, you had no opportunity to discuss that with her?

A. DAWN: Correct.

A. CRAIG: Correct. I mean, other than whenever we did challenge things, we were never consulted about a decision. So it was made -- they made that decision, which was in some cases maybe fair enough, but I would certainly expect to be engaged on some of the more serious items or decisions made like sectioning and coming off of section, but we never were.

Q. As far as you are both concerned, what was the overall effect or impact of that period under section? Do you think it had made any kind of difference to any aspect of your mother's progress or her --

A. DAWN: Made it worse.

A. CRAIG: It deteriorated.

A. DAWN: Without a doubt.

A. CRAIG: Obviously those comments and records suggest exactly that from mum's feelings.

Q. Yes. And the regularity with which she was expressing to

you in particular, Dawn, her wish to die and that she couldn't stand to be a prisoner anymore, I think is how she put it. The 14 January when the decision was made not to extend her section was also the day on which your mother made her first attempt to ligature.

A. DAWN: Correct.

Q. And that took place in her bathroom, in the bathroom of her room on the ward.

A. DAWN: Correct.

Q. What we know now, and I am going to come back to the way in which you found out about this, but what we know now from the records is that on 14 January for certain no information about that incident was communicated to any of you.

A. DAWN: No.

A. CRAIG: No.

Q. No records from that date reflect the incident, the fact that she had attempted to ligature.

A. CRAIG: No.

A. DAWN: Nothing in her plans at all.

Q. No records from that date reflect the injuries that your mother had sustained during that incident.

A. DAWN: Correct.

Q. Those injuries, forgive me, were primarily major bruising -- major facial bruising and bruises to both

sides of the head and dental injuries; is that right?

A. DAWN: Correct.

A. CRAIG: Certainly injuries that wouldn't go unnoticed to the naked eye.

Q. They were obvious facial injuries.

A. CRAIG: Obvious, very, very obvious.

Q. Thank you. We also know from the records that the only treatment provided to your mother, having attempted to ligature on 14 January, was paracetamol and to have her blood pressure taken.

A. DAWN: Correct.

Q. There was no physical Examination by a doctor until two days later at 7 pm pm on 16 January.

A. DAWN: I don't thin they even spoke to mum, questioned her to see if her story was true, because I think at first mum said that she had had a fall.

Q. Yes. You think at first she said she had had a fall?

A. DAWN: Yes.

Q. Right. I will come back to that if that is all right, because the first that you knew of this incident was that, is this correct, you must tell me if I have the sequence of events wrong, your father called the ward on 15 January, so the following day, and was told that he couldn't speak to your mother because she had gone for treatment because she had knocked a tooth out?

A. DAWN: Yes. My dad had come to my house on that 15th and that's when he said to me, "Mum's had an accident that she's had to go to the dentist, she's knocked a tooth out."

Q. Was he told that she had had an accident by staff? Not by your mother? He didn't speak to her at that time, did he?

A. DAWN: He didn't speak to her, he was just told that he couldn't speak to mum because she had gone for treatment because she had knocked her tooth out.

Q. And then at around 4.30 pm on the same day, so 15 January, you did manage to speak to your mum.

A. DAWN: Yes, I phoned her.

Q. That's not the same -- so that's later in the day and your mother was quite plain with you that she had tried to end her life; is that right?

A. DAWN: Yes, after some questioning, yes, because I was asking her about the accident because I think she said that she had slipped or something like that. And I had asked her "Where?" And she said that she had hurt her face on the wardrobe. Well there wasn't -- between her bed and the wardrobe there was no space to slip and hit your head, and I was asking if the floor was wet, just generally trying to get to bottom of why she had gone to the dentist and that's when she just said she was sorry

and, "I did it."

Q. I think she then went on to give you some fairly substantial details about how she had tried to ligature.

A. Yes.

Q. You tell us about those, we will come back to them, at paragraph 97 on page 24?

A. DAWN: Yes.

Q. And then I think, is this right, you -- was your father still with you, because you gave the phone to him and he carried on talking to your mother?

A. Yes.

Q. While you contacted the ward?

A. That's correct, yes, I was trying to keep mum engaged where as I realised something was seriously wrong and hence I phoned to speak to the ward manager.

Q. And you did that and you spoke to the ward manager whilst your dad remained on the phone with your mum and you were told that it wasn't true.

A. DAWN: There was nothing wrong and that my mum was just attention seeking.

Q. The ward manager also said to you, I think, that she was simply trying to raise your anxiety as a family.

A. DAWN: That's correct.

A. CRAIG: That was a consistent line and if you remember, going back to when Dawn was travelling to Cornwall, it

was just a consistent line they took that, you know, mum's behaviour was just there to ... more hinder us or aggravate us to do things, rather than any real concern.

Q. Yes. Now, your legal team have undertaken -- you recall that and you had recorded it yourself in your own notes.

A. DAWN: Yes

Q. But also your legal team have undertaken this analysis of medical records and I am looking at paragraph 100 on page 24, NEPT's own records confirm that the ward manager told you that it was not the case, that's at the very bottom of page 24, Dawn.

A. DAWN: Yes

Q. Now I understand by that that those records are saying it was not the case that she had made an attempt to ligature.

A. DAWN: That's correct.

Q. And:

"'... staff are aware of Iris at all times due to her fluctuating levels of anxiety'."

It is your belief now, or quite soon after, that a great deal of what you were being told was to try to prevent you from going to the ward?

A. DAWN: Yes, definitely. I said that I would come in and they said that there was no need to come in, that everything was fine and then, obviously, I was just

questioning what was happening, why had she gone to the dentist, we was obviously looking at something, that something had happened basically.

Q. Yes.

A. DAWN: Until I went the next day I didn't realise the seriousness of what we saw and what had happened.

Q. No, because on the 15th, of course, you had no idea of the injuries we just described.

A. DAWN: No, not at all.

Q. You thought there was just a problem with a tooth.

A. DAWN: Just a tooth.

Q. The records show that in fact on the 15th your mum's observation levels were raised to level 2 but you didn't know about that at the time.

A. DAWN: No.

Q. You had just been told that it wasn't true and that there was nothing wrong. Then the records from the 16 January, so the following day, tell us that at the ward review it was decided that level 2 observations were to remain in place, that all risky items were to be confiscated from your mum, and that there would be some additional medication, essentially some changes to her medication; yes?

A. DAWN: Correct.

Q. The extent of her injuries became clear to you

immediately, I think, on the afternoon of that day when you visited with your father, Dawn?

A. DAWN: That's correct.

Q. Not only could you see the injuries she had sustained to her face, I understand that during that visit your mum showed you, she walked you through what she had done on the 14th to try to ligature.

A. DAWN: Yes.

Q. And what she showed you involved a fixed ligature point in her bathroom.

A. DAWN: Yes.

Q. A chair.

A. DAWN: Yes.

Q. And a cord item or belt item.

A. DAWN: Yes.

Q. At that point, as I understand it, Dawn, you approached staff and started to talk to them about what had happened and what your mum had just shown you and that staff member insisted during that conversation that your mum had simply had a fall.

A. DAWN: Yes, it was mum's key worker.

Q. That was her key worker?

A. DAWN: Yes.

Q. There is then a slightly bizarre turn to this conversation between you and the key worker in which, as

I understand it, the key worker tells you that your mum couldn't possibly have ligatured because she was being observed every 20 minutes.

A. DAWN: Yes.

Q. And help me to understand this, you say looking at the middle of paragraph 103 on page 25 --

A. DAWN: Yes.

Q. -- starting about halfway down, with the sentence starting "I explained", do you see that?

A. DAWN: Yes. Because I was explaining to the key worker that they said she had a fall and I said, "Well, if she's got bruises on both sides of her head and under her eyes and everything", and the way that the item had broken, the key worker suggested that she must have cut it with some scissors. I obviously questioned that, how would my mum have some scissors or a sharp --

Q. Can I stop you for a moment? So there was a breakdown item that your mother told you she had used --

A. DAWN: Yes.

Q. -- to try to ligature, and you saw that broken cord.

A. DAWN: Yes.

Q. And you pointed out to the key worker that there was no explanation for that if what had happened was simply a fall.

A. DAWN: Correct. And she suggested about the scissors

and, you know, why on earth would my mother have scissors or have access to scissors on level 2 observations, let alone in a psychiatric ward, and she then suggested that mum could have damaged that cord by rubbing it on the windowsill, so where the window was open, to -- because it was frayed it hadn't just broken it had frayed broken.

Q. I see.

A. DAWN: But obviously in the ward the windows don't open very far at all, they give enough ventilation for air but for obvious reasons they don't open as an escape risk. So I don't know -- I don't know why she was going to the lengths when --

Q. Of making those suggestions?

A. DAWN: -- we had produced an item which she had clearly used and mum had gone step by step through how she had done it, it was basically covering their backs.

Q. At that point you called Craig and asked him to come immediately to the ward.

A. DAWN: Yes, definitely. Craig was at work and I would never call him at work if it wasn't, you know, something serious. I didn't even say to Craig exactly what, I just said I needed him to come as soon as possible.

Q. I understand. And, Craig, I understand from your witness statement obviously that you did go straight to the ward and that Dawn was waiting for you in reception, explained

to you the circumstances we have just described and that both of you were told that your mother had been sent to her room because she was very agitated.

A. That's correct, yes.

Q. You both went to her room together and on doing so, what you saw was your mum setting up the ligature in exactly the way she had described to you.

A. CRAIG: Yes.

Q. Using the same or similar items.

A. DAWN: Yes, exactly.

A. CRAIG: And bearing in mind that I was working locally at the time so it didn't take me long to get to the hospital. So from the time that Dawn had initially engaged with mum and for the time I got there wasn't long at all, so you know, there wasn't a delay where perhaps mum had a long time to think about this. She was sent to the room and she was ...

Q. She was sent to her room and straight away --

A. DAWN: By herself.

Q. -- started to make this attempt.

A. CRAIG: She was on her own, left on her own.

A. DAWN: So why was she sent to her room be herself? Why, having discussed that with the key worker and there was my father there as well, why had they not taken that opportunity to sit with her. I was literally going out

of the ward to meet Craig.

Q. Craig, I understand that it was you who immediately went to reception or to the desk --

A. CRAIG: Yes.

Q. -- to report there was an urgent situation.

A. CRAIG: Yes.

Q. There were no staff around that you could see.

A. CRAIG: Not initially, no. When I say "not initially", there was no one at the desk initially and then literally probably a couple of minutes later, one of the junior members of staff arrived and I said, "We have an issue, we need the ward manager, we need some senior staff." I was told, "Just give me a minute", I said, "I'm not giving you any time at all" --

Q. There are no minutes.

A. CRAIG: No. "You get the appropriate staff members and come to my mum's room immediately. We have a problem."

Q. Yes. And the person who did come was the senior member of nursing staff?

A. CRAIG: Yes, accompanied by, if I believe, one or two other members of staff.

Q. I see. And this is what we touched on earlier that you felt that that response really someone had thought actually a serious failing has occurred --

A. DAWN: That's correct.

Q. -- and we are going to need to address this with this family.

A. CRAIG: The course of events, from what I recollect, was when they arrived and they realised that there was a concern and there was something they needed to address we were asked, Dawn and I, to go and wait in reception.

Q. Yes.

A. CRAIG: So that's why I think, I'm not sure if the head of the ward was initially present at the room.

Q. Yes.

A. CRAIG: But whilst Dawn and I were waiting in reception that's when the head of the ward arrived and at that time Dawn and I had, we're not telepathic by any stretch but I know we both had the same thought, the only reason why she is here is that there is a problem, they have sent the big guns to come and speak to us.

THE CHAIR: Was that the ward manager?

A. CRAIG: I have to be careful how I define it, I'm not sure if it's the ward manager, I think we have to be careful.

MS TROUP: Are you talking about the clinical manager?

A. DAWN: No, we are talking about *(redacted)* -- sorry.

Q. It's okay, it's all right.

A. DAWN: The key worker.

A. CRAIG: She was in charge of the running of the ward on a

day-to-day basis, so you have probably got managers above who were probably technically closer to ward managers, but she was in charge of day-to-day operations managing that ward and everything around it so --

Q. You waited -- no --

A. **CRAIG:** As soon as she arrived, body language was completely different, it was more engaging almost warming, probably trying to calm us down not to agitate us any further than perhaps her previous demeanour might have done. A quick conversation, sort of let us settle a bit, and then we walked through and then I think, Dawn correct me if I am wrong, I'm not sure if we went straight to the room again or we went to the communal area of the ward. I can't remember.

Q. To wait, yes, I understand.

A. **CRAIG:** But we witnessed, in probably that period, the two other members of staff going through mum's room, removing other times of concern.

Q. Can I ask you about that please, because I just want to ensure that I am clear on this. I understand that before leaving the ward that day, one of the things that you did was impress upon staff that you must be informed of incidents like the incident that had taken place on 14 January. And Dawn, can I ask you please to turn to page 28 of your witness statement and to paragraph 117. This

is actually about a different period, but if you look at the last three lines there, I just want to ask you whether it is the case that on 16 January, which is the day we have just been talking about, is what you mean there that on that day, 16 January, before you left, you found a cord in your mother's room, or are you talking about a different day? A better way for me to put it might be before you left the ward on 16 January, did it occur that you found any cords or risky items in her room?

A. DAWN: She had shown us the cords and obviously we had shown that to the staff.

Q. And they had been removed?

A. DAWN: I thought they had been removed. It was when I went into the ward on the 20th and went to mum's wardrobe -- because as I stated before I used to do mum's washing, to get her dirty washing out and that's when we had discovered the two items that had been fixed together were still in the bottom of her wardrobe.

Q. Yes. That was on 20 January?

A. DAWN: Yes.

Q. I think it was the case that after that incident, and after you had left the ward, a decision was taken and again this is what the records tell you I'm not sure it was communicated to you, but you will tell me if I am

wrong that level 2 observations would remain in place, and the decision was taken that you discussed a little earlier that your mum would be placed on restrictions and the effect of that was that her bedroom door would be locked between 9 am and 10 pm every day, such that she could only access the main or communal areas of the ward.

A. That's correct.

Q. Now, given all that we have learned so far about the ward environment, and the functionality of the majority of the clients and the time that your mother was spending alone in many ways, those decisions about restricted access to any kind of private space, I think your impression is that those worsened her condition?

A. **DAWN:** Yes, it just escalated the whole situation because she obviously was in a very low place at that time by her actions, and also the staff weren't believing her story and I think there was a situation, I think you may come on to that.

Q. No, go ahead.

A. **DAWN:** There was a situation where the ward manager went into my mum's bedroom and shouted at my mum that she had overstepped the mark this time and --

Q. This is 18 January, I think, this conversation?

A. **DAWN:** This was after, obviously, we had raised the issue. They had then made notes and examined mum two

days after anything had happened.

Q. But on the 18th, as I understand it, when you visited your mum, what she told you about the conversation she had had with the ward manager --

A. DAWN: Yes.

Q. -- who was, according to your mum, overtly angry with her.

A. DAWN: Yes.

Q. Said that she had overstepped the mark.

A. Her boundaries.

Q. She had gone too far this time.

A. DAWN: And not to ask about medication or anything.

Q. Not to present any kind of challenge.

A. Yes, slammed the door and walked out.

Q. Slammed the door, but I think what your mum told you was -- she didn't necessarily name the ward manager, but that staff had tried to get her to change her account about what had happened on the 14th.

A. DAWN: Yes.

Q. So that first attempt.

A. DAWN: Yes, and I think that's why, as well, mum was so desperate, determined to show Craig and I what she had done because she wanted someone to believe her.

A. CRAIG: She wanted to be heard. She wasn't being heard in there and, you know, I guess she also had concerns

that perhaps we were siding, although we were obviously engaging with mum, maybe in her mind we were siding with the ward, or could side with the ward's narrative about around what had happened. But clearly evidencing to us the process she had gone, she had attempted, that was her way of communicating to us her real intent.

Q. She was desperate for help?

A. CRAIG: Yes.

Q. On the same day, 18 January, I think again at your request the independent advocate also visited the ward, and he was told that she had had an accident by banging her head on the wall?

A. DAWN: Yes.

Q. Which is slightly different again, isn't it?

A. DAWN: Yes.

Q. The purpose I think of having the independent advocate intervene at that time is because you were so concerned that nobody was investigating what had actually occurred on the 14th?

A. DAWN: Yes, that's right.

Q. And I think is this right, a major part of the issue was what your mum had raised about some pressure being put on her to change her account about what had happened?

A. DAWN: That's correct, that was on the 18th as well. It's difficult to phrase this but --

Q. You phrase it as you want to.

A. DAWN: They actually said to her that if she didn't change her story, they were --

Q. They were going to reveal something about her.

A. -- reveal something that didn't need to be revealed and it was blackmail, basically.

Q. So that threat was made.

A. DAWN: Yes.

Q. And your mum told you about that on 18 January.

A. DAWN: Yes.

Q. She also, I think, said that she felt a huge change in the way that staff were treating her. It hadn't been optimal previously.

A. DAWN: All right all the smiles had stopped and there was shunning, I suppose, really, is probably ...

Q. You felt very strongly, I think, that she was frightened?

A. DAWN: Yes, definitely, of course she was frightened. Obviously she was worried about the whole situation that they had made these threats to reveal something about her and also, I mean, that's no way to treat her after something like that has happened to tell her that she has overstepped the boundaries and don't ask for anything. They should have been going totally the opposite way and spending all the time with her and doing their best to make -- how could they make good, they can't --

Q. Provide therapeutic care.

A. DAWN: Yes that's right, doing their job.

A. CRAIG: Why put additional pressure on someone in a very fragile situation like that, it just doesn't make sense unless you've got your own agenda, which probably they did and maybe they have.

Q. Tell me this was the point I think at which you considered putting cameras into her room?

A. CRAIG: Yes, we were clearly, by this stage, at a loss and very, very uncomfortable with the situation or the environment that mum was in at the time. From the engagement, or lack of, with the nursing staff and the only engagement we did have with them was difficult at best, so to try and understand what mum was going through, you know, if you remember back to the quotes of, "You don't know what it's like in here."

Q. Yes.

A. CRAIG: We thought, well, perhaps we need to know what it's like in here and so the only way to evidence that was, you know, perhaps we could put some cameras in her room, inadvertently, secretly.

Q. You decided against?

A. DAWN: Yes, probably the worst decision we made.

A. CRAIG: I mean, probably the worst, but how things ended up, maybe the best, in some respect. But that would have

been difficult viewing of course, but maybe we would at least have the truth that we don't have today.

Q. I understand. After that incident, I understand that throughout January and February, in summary, risky behaviours escalated.

A. DAWN: Yes.

Q. And it became very clear that your mother was desperately crying out for help.

A. DAWN: Yes.

Q. She was seen accessing another patient's belongings and asking another patient for a belt or cord of some kind.

A. DAWN: Correct because we had taken everything away by that time, anything that was in her wardrobe.

Q. You found, as you described to your horror, items that could be plainly used to ligature in her wardrobe when it was unlocked at your request?

A. DAWN: Yes.

Q. You discovered she had somehow tried to use a staff access card to access her room.

A. DAWN: Yes, for some unknown reason even though the door to mum's room was locked, obviously the staff had a PAC tag to access those rooms. Sometimes if mum asked they would give her the PAC tag to go into the room by herself. What's the point then of locking outside of her room and keeping an eye on her and then on the other hand

saying, "There you go, Iris, off you go."

Q. And allowing her to access her room with their card.

A. DAWN: Without any supervision.

Q. We learn from the serious incident report that in January staff observed your mum placing an item of clothing that could plainly be used to ligature with inside her pillow case?

A. That's correct, yes.

Q. And those behaviours continued to escalate. I want the take you, please, before we move on to what eventually happened to the CPA meeting on 23 January that you both attended?

A. CRAIG: Yes.

Q. That meeting was attended by both of you, your mum's psychiatrist, care co-ordinator, the nurse in charge on the ward and a senior manager.

A. CRAIG: Yes, I think it was Glynn --

A. DAWN: I think our brother was there as well.

A. CRAIG: And I'm not sure if dad was there as well.

A. DAWN: I think he was.

A. CRAIG: I think he was.

Q. The major concerns you were raising was the fact that when you called the ward on the 15th to find out what had happened on the 14th, you were told that your mother was attention seeking.

A. DAWN: Yes.

Q. The fact that there appeared to have been no proper investigation of that incident and the fact that your mum had told you that staff were trying to get her to change her story or she would be in trouble?

A. DAWN: Correct.

Q. You also raised issues around her care and treatment at that meeting, but focusing on those major concerns about what had happened on the 14th, as I understand it, there were some sort of conflicting -- it was a conflicting meeting in that one member of staff accepted that that had been a ligature attempt and apologised and said that efforts would be made that it wouldn't occur again.

A. DAWN: Yes.

Q. But your mum's psychiatrist said that he wasn't 100 per cent sure that it was an attempt to end her life and that there wasn't clear evidence either way.

A. CRAIG: I don't remember that part, if I'm honest, but I do remember the ward management accepting and admitting that they now could see that it was an attempt.

Q. They now did?

A. CRAIG: They now did concede that it was an attempt.

A. DAWN: And they kind of set up at that point and said from there on they intimated they were going to make things better but it was too late. My mum was too low,

it was too late.

A. CRAIG: And I'm not sure Rachel, if you are going to touch on this but at that point, that meeting then, following on from our suspicions and our concerns thinking about having a camera in the room, I decided to, or we agreed to record that meeting surreptitiously.

Q. So you have that recording of the meeting?

A. CRAIG: That's why I particularly remember the staff agreeing that there was an issue and conceding to that effect, and I remember Dawn, just to touch on that point, I remember the point she felt like we had gone too far. There was no turning back now. Mum's condition had deteriorated, that far, there was no turning back.

Q. I see. That was on 23 January and the very next day, Dawn, as you were handed an envelope containing your mother's belts, bearing in mind that she had been on restricted access to her room since 15 or 16 January.

A. DAWN: Yes.

Q. She also in early February told you a little about the way in which she was being treated, and I think there was a particular incident where a staff member threatened -- bearing in mind her history of poor sleep and anxiety around that, a staff member she had asked to turn the lights off at night had threatened to leave them on all night if she kept complaining about it?

A. DAWN: Yes.

A. CRAIG: There was another incident as well, apologies if you are going to get to it, but there was a male member of staff, quite a big gentleman.

Q. Yes.

A. CRAIG: I think there were suggestions of bullying by him, where he would instead of making way in a corridor to let mum pass he would block her path. I'm not sure how forcefully he did that, but those were the sort of things that mum suggested he had done.

Q. She suggested that to you, she told you about that?

A. CRAIG: Yeah.

Q. She told you about that?

A. CRAIG: Yes.

Q. Thank you. I think also you have told us that you took your mum's washing home?

A. DAWN: Yes, that's correct.

Q. On 3 February you found a pill, some sort of medication in the pocket of her jeans.

A. DAWN: I did, yes.

Q. And called the ward, spoke to the ward manager who said, "Oh well".

A. DAWN: I essentially showed them. They came back and said, "That's not one of your mum's tablets, that's not medication she's on." I said, "You are missing the

point, how has my mum got anybody's tablets, how has she got this medication?" And it was just dismissed, it was almost, "Why are you raising this point, we don't see it as an issue".

A. CRAIG: If you remember from the earlier matter, almost first this morning, I said about staff having adequate training and the controls and oversight of staff as they progress up that, those qualification periods, so they can clearly be responsible for people in that position, I would suggest that's probably one of the reasons why that happened. You had a junior member of staff not adequately qualified, not adequately supervised when distributing medication to a wide number of patients at one time. Because they would regularly leave the station to go and administer.

Q. To go and do that?

A. CRAIG: Yes.

Q. I understand. Can I take you please to 11 February and, in particular if we can look together please at page 32 of your witness statement, Dawn, and paragraph 139. Now, we recall that you told us that on Christmas Eve you had had a feeling that your call with your mum was being listened to.

A. DAWN: Yes.

Q. Here we see, and this is 11 February, that the records

show -- are those, we think those are NEPT records, are they?

A. DAWN: Yes I believe so yes.

Q. That your mum had approached staff and asked to be allowed to have private telephone calls with her family, and you say there in response:

"It was explained to her by staff that following her behaviour during her husband and daughter's visit the previous day, it was felt necessary to monitor conversations with her family."

Now, you had no discussion with anyone about that at the time --

A. DAWN: No, absolutely not.

Q. -- because you didn't know?

A. DAWN: And as I say the feeling I had, it was just purely a feeling, I didn't know back at Christmas time that my call was being listened to. It was just a feeling I had from the click on the phone. Obviously they were listening to far more than we knew they were.

A. CRAIG: Or we had given them permission to.

Q. I am sorry say that again?

A. CRAIG: Or we had given them permission to. Maybe they don't need permission but I would expect them to have given us --

A. DAWN: I don't know why they were listening.

A. CRAIG: At least inform us that that was the case, but I guess that's consistent with their lack of engagement and information that didn't flow to us during the course of mum's treatment.

Q. I understand. I would like to take you on, please, to the circumstances leading up to your mother's death. We know that between 11 February and the 28th there had been a number of further medication changes.

A. DAWN: Yes.

Q. We see a note in the records where the psychiatrist is questioning whether there is a genuine mental illness or again we see this phrase around personality problems.

A. DAWN: Yes.

Q. Again, presumably nobody discussed that with you.

A. DAWN: No.

A. CRAIG: No.

Q. Because you didn't know that those were their considerations at the time. What we know is that the records on 27 February show that it was decided that there would be a review of the restrictions your mum had been placed under --

A. DAWN: Yes.

Q. -- in terms of her access to her own room, and so on, and that her psychiatrist decided that those would be lifted after the ward round if there were no other concerns?

A. DAWN: Yes, but I think on -- I think it was on the 27th when mum was having the meeting, it was by a doctor that didn't know mum.

Q. I see.

A. DAWN: I think the psychiatrist was busy on something else and that that doctor had questioned mum about her feelings. She had said that she wouldn't do anything to hurt her family and that even if she could have access to risky items, she wouldn't know what to do with them. Well this was clearly untrue because she had shown for the previous three months that any time that she could get her hands on an every day item that could be deemed risky, she certainly did know how to use it. He took mum's word as that was it, she wasn't going to do anything and she was lifted from level 2 restrictions.

Q. Yes, and she was allowed access to her own bedroom again.

A. DAWN: Yes.

Q. That decision was taken or I think or the restrictions were lifted fairly late on the 27th, you came to learn of this the next day, the 28th?

A. DAWN: Yes, I was told in a phone call in the morning and I immediately asked for CPA meeting because I couldn't believe with what had happened over the last few weeks, that they was actually lifting those restrictions without consulting us, and as I said before, with a doctor who

didn't know mum. She clearly stated -- she clearly had the intention and knew what to do with risky items. Unfortunately that meeting was arranged for a few weeks' time, so our brother, who was living over in Germany, could fly over and come. As we know, 24 hours later she wasn't with us.

Q. Yes. What your mother said to that doctor on 27 February was, as you say, taken at face value and that was despite the fact, I think, that there were some conflicting accounts. So we can see from the records, for example, that on 13 February your mum is recorded as having said to staff that actually the family was not a protective factor and that she wouldn't miss her grandchildren, she didn't have feelings for the family. I don't suggest that that communicates anything other than utter desperation but the record was there --

A. DAWN: Yes.

Q. -- to be noticed.

A. CRAIG: Yes.

Q. We also know now, moving into the evening and night of 28 February -- I am sorry, 28 February that there was some sort of incident, meaning that staff had left the ward and the ward environment was in flux or slightly chaotic at the time; yes?

A. DAWN: Yes.

Q. The ward records, or NEPT records, tell us that a staff member found your mother hanging in her bathroom at quarter past midnight on 1 March 2014.

A. DAWN: Correct.

Q. What he describes having found, if can I put it in this way, is an exact mirror of the items and system your mother had described to you from 14 January and that you yourselves had seen on 16 January. Is that a fair description?

A. CRAIG: Correct.

A. DAWN: It is a fair description and it was exactly 24 hours after being taken off of observation for the significant attempt on 14 January, and this was less than 24 hours after being taken off of observations.

Q. Yes. The nurse who is said to have found your mum also says in his statement to the Inquest or his in his account, that when he had come on to shift at 8.30 pm, he had been informed that your mum had been offered some sedative medication because she reported feeling very anxious. You considered that that ought perhaps to have triggered some sort of alarm bells, given that restrictions had just been lifted.

A. DAWN: And she also said to the person, "There's no need for you watch me tonight."

Q. Where do you know that from, Dawn, do you know? I can

see it in your statement?

A. DAWN: Yes.

Q. Paragraph 152. It doesn't matter very much but I just wonder --

A. DAWN: I must have been told, it must have been in one of the statements, for me to know that because obviously I was not there. I left the ward probably about half five, whatever dinner time was, it was around dinner time, when I left the ward and mum had had her hair done that day. She was in a sober, somber mood. She was quite within herself, but I left the ward about half five or six o'clock that day. So it must have been in one of the statements for me to know that --

Q. I understand. Please don't worry, I understand.

A. DAWN: Because obviously I was not there and I wasn't able to speak to her.

Q. Please don't worry, I understand. But in your mind, in any event, an in-patient in these circumstances telling staff that they don't need to be checked on is an obvious trigger for concern?

A. DAWN: Yes, correct.

Q. I understand, and you must tell me if I have any of this wrong, but both of you have very grave concerns about the sequence of events on that evening as presented by ward staff, and in part that is because although the staff

member I have just referred to reports finding your mum at about quarter past midnight, in fact, we know from ambulance service records that the first call to ambulance services was made at 36 minutes or 35 minutes -- no 32 minutes past midnight, I am so sorry.

A. DAWN: That's correct but my mum's door was not accessed before 25 minutes past 12. In fact, the senior nurse had gone sick that evening, there were bank staff in. Basically they were short staffed that night. They only had one card between the three people that were on duty to access rooms and one of the -- the person that had the card was in a different part of the Crystal Centre, so he was actually out of Topaz and Ruby Ward. He was still within the Amethyst Centre, but he was photocopying at the front.

Q. I understand.

A. DAWN: So he was nowhere near that area and there was a gentleman that was on level 2 that should have been being watched every 20 minutes in the bedroom opposite mum's, but that card did not access the room until after he said that he saw mum.

Q. And you know that having sought to obtain the records of the access card from the Trust?

A. DAWN: We asked for the PAC tag report for that night so we could determine where the people were on the ward.

A. CRAIG: And it goes to the consistency that from previous attempts and how the Trust, the board, had tried to, in our view, cover up certain, especially the first attempt, again tried to get mum to change her mind and dismiss it, et cetera, and the inconsistency of the events on the night, naturally we can only -- we speculate, we just can't get comfortable with what is being presented to us by the board, or by the Trust, on the events of that night. It's very difficult to accept. Too many inconsistencies.

Q. I understand, and in terms of the cover-up that you have referred to from earlier in January, I think your feeling, both of you, is that had you not been there on the 16th, and witnessed your mum doing what she did, that event of 14 January might actually have forever been dismissed as a fall. It might not have been accepted that that was a ligature attempt; is that fair?

A. DAWN: Yes.

A. CRAIG: Yes, I would agree. What didn't help the ward and the Trust was the significant injuries that mum sustained. There's no way they could cover that up and yet mum's, her local key worker --

A. DAWN: Yes.

A. CRAIG: Bearing in mind she was supposed to be dealing with mum on a regular basis, at the coroner's inquest

actually denied ever seeing mum in that condition.

Q. So that key worker denied having seen the injuries after 14 January?

A. CRAIG: Correct. And, you know, these weren't slight superficial injuries that would go --

Q. Unnoticed.

A. CRAIG: You could see them from a good distance away.

A. DAWN: It was the community care worker, wasn't it? And she had actually taken mum to the dentist and she accused mum of continually prodding her face to make them worse. Mum was prodding her face because she could obviously see where it was so swollen, she could see, you know, and she could feel.

Q. And feel presumably, of course. I understand that the serious incident report that was later published, and I will ask you a few things about that, was really, for both of you, notable in what it missed rather than what it did contain, because what we know, having now talked through the events of 14 January and 16 January, and knowing that the events in the early hours of 1 March 2014 mirrored both of those events, is that somehow, despite all that had occurred, your mum remained in possession of an item that was obviously risky, a fixed ligature point remained in place and nothing had been actioned or changed about those matters.

A. CRAIG: Not only the items that mum used, that she had, if you like, for her personal items. You touched on the point and it's the chair, the chair that mum used in the initial attempt and then ultimately, I hate to say it, successful attempt, was a very heavy chair. I used to have to move it. So if I went to visit mum and she was sort of sitting or laying on the bed I would move that chair. Now I don't consider myself -- I'm not the strongest person in the world but I am by no means the weakest and it took reasonable effort to move that chair. It wasn't the standard chair that we are all sitting on today. For someone in mum's condition, frail, that would have taken significant effort on both occasion to move that chair, to drag it across the floor, it must have made a noise.

Q. Dragging across the floor?

A. CRAIG: Dragging -- admittedly, she is not moving it ten yards, she is probably dragging it three to four yards to the area needed but it would have taken significant effort. Had the ward on both days been suitably staffed, it couldn't have -- you would have definitely heard it.

Q. Yes.

A. CRAIG: So it's just, you know, but you go back to the first attempt, why wasn't that identified and that item removed? Again another failing.

Q. Yes. You also, I think, questioned the item that your mum used on 1 March 2014 was a scarf and it was found to be her own and she must have brought it from home, and you questioned why she was allowed to have that in her room given all that has taken place by then.

A. DAWN: Definitely.

A. CRAIG: Well there was a significant search -- as I touched on earlier, we witnessed them going through the wardrobe on the, was it the 15th or 16th, cleaning out -- I'm sure there was a hair dryer, belt, everything. So why wasn't it identified then? There were other occasions as well, so there is no excuse for that time to be there, it's not like mum had had a home visit or we had brought it in. Clearly, we would never do such a thing. So there was just no excuse for having an item, an everyday item like that in her room.

Q. Yes. I understand that you have learned -- it had always been your impression that your mum had died before 2 am.

A. DAWN: Yes.

Q. Because that's what you were told, and in fact ambulance service records show that when they attended your mum was in what they call "workable arrest", and ambulance service records tell you that she was recorded as deceased at 2.17 in the morning. You have questions, I think, that have never been answered around training for

the resuscitation and the use of the defibrillator and what happened in those minutes when ...

A. DAWN: Well, as we said before, mum's room wasn't entered until 25 minutes past. It should have been obvious this was an emergency. However, an ambulance was not called for ten minutes.

Q. Yes.

A. DAWN: We are at a hospital. There's an ambulance station right outside the hospital gates. Also they contacted the doctor on call at the Linden Centre who didn't turn up until same time later because he said he didn't realise it was an emergency.

Q. Presumably only because someone had not communicated to him that it was an emergency?

A. DAWN: Well, obviously, yes, I think the issue was also that they didn't have a mobile phone. There was only one phone which was at the nurse's station so they were having to relay. I appreciate it was probably quite a distressing time in the ward but they had to go back to the nursing station. But one of -- the nurse, female nurse that was on duty said that my mum had a faint pulse. We were told it was a workable arrest.

Q. Yes.

A. DAWN: The nurse that found mum said that she was standing facing the door. *(...Redacted...)*

As I described before, mum was five foot tall so that scarf would have had to have been very long (...redacted...)

[Gist: The witness questioned whether the described circumstances of their mother's death were physically possible, noting that aspects of the account did not appear consistent with her mother's height, the objects said to be involved, or the layout of the room. They expressed doubt about how the situation could have occurred as described].

Combined with the pulse, a workable arrest and nothing was called. What happened in those ten minutes when something could have been being done and wasn't? Basically she should still be here.

Q. Thank you. Craig is there anything that you want to add there before I move on?

A. **CRAIG:** It's just, I don't understand how there can be so many inconsistencies on an event with a relatively small timeframe.

Q. Yes.

A. **CRAIG:** People have different recollections of different events, I understand that, especially in high stress environments. But there's, what I would call unrefuted evidence of times when doors are opened, closed, calls are made, et cetera. Why wasn't that relayed to us at

the time? We are finding out a lot of things ten years later.

Q. Yes.

A. CRAIG: I just find that unacceptable and it just makes me wonder what -- why? Again, that's just, that's the big question.

Q. Thank you. One of the things you note, Craig, about the serious incident report is that once you had read it, you didn't consider it really worthy of further scrutiny.

A. CRAIG: It wasn't fit for purpose.

Q. It doesn't mention --

A. CRAIG: For me it was a copy and paste from some other, I don't think mum's name was even mentioned correctly. It was a --

Q. I think you received a copy of it that named her as Mrs Smith, did you not?

A. CRAIG: Yes. I mean, how can someone not proofread that before you put it in front of two grieving relatives? And have that respect and care and attention to detail -- I say attention to detail, I mean that's the basic to at least have the name of the deceased presented correctly. Let alone the overall content of that document. It just wasn't fit for purpose, it was a waste of time.

Q. It didn't, in fact, address in sufficient detail in your view, any of the matters we have just discussed how that

item came to be in your mum's possession. The fact of the ligature point that was used, a fixed ligature point in a bathroom, how staff dealt with those minutes that you have just described or the inconsistencies between ward staff timings and ambulance staff timings. None of that was addressed.

A. CRAIG: I would say that report was more there to protect the ward and the Trust than it was to address the issues that happened on that evening and leading up to it. It wasn't a serious report to say where the accountability is and where we can make improvements. It was how can we protect what we have and make best of a bad situation? That's putting it politely.

A. DAWN: I think one of the statements from the female nurse that was on duty that evening, her statement wasn't taken till 25 May, a significant time after the event, for something that, as the report suggests, is a serious incident and they are investigating their own.

Q. Yes. For that reason I think, you tell us in your witness statement, that actually you felt fairly dismissive of the process from the start. They are marking their own homework.

A. DAWN: Yes.

Q. In terms of the inquest, I know that that took place in June 2015. There had been a delay because there was a

delay in disclosure on the part of the Trust as I understand it, it had been due to take place in March 2015, finally took place in June 2015.

A. CRAIG: Some of that was at our request.

Q. I see. Thank you.

A. CRAIG: Because March, we didn't want March, it was so close to the anniversary. We had dad's birthday in early April. So the delay didn't help but again it goes back to their initial suggestion of March 2015, almost a year to the day after the event, you know, what was their thinking?

Q. Their thinking. I think both of you say in slightly different ways in your witness statements, but you must tell me, that you felt -- I know that Dawn you did, you found INQUEST, the charity, and then found some legal representation, but your overall impression was that the process leant towards the Trust. Help me with what you mean by that?

A. DAWN: They seemed to be more obstructive, and I remember with the Coroner, when I was trying to especially talk about the attempt and mum's final act.

Q. Yes.

A. DAWN: They just kept saying this is not an investigation. This is an inquest. We just wanted to get our story across. Again, I can't understand when you

have so many deaths in one particular area, which are all going through one Coroner's office, how this was missed for such a long time.

Q. Thank you. There was no prevention of future deaths report, was there?

A. DAWN: No.

A. CRAIG: It felt like to me and I would only describe it as institutional bias. In that, our initial barrister and the Coroner clashed, so much so that we had to -- well, he removed himself from the process, which massively hindered the process for us. So we had to get someone else in, get them up to speed with what's gone on, and then go again. It just every challenge was always -- every challenge that we put forward was rejected and it seemed that everything that the Trust put forward was accepted. That was my first experience of ever being in a situation, in a courtroom, an environment such --

Q. Proceedings.

A. CRAIG: In proceedings such as that. I couldn't believe, although I was very much immersed with it, I couldn't believe what I was witnessing or being part of. I expected mostly the Coroner to be leaning on our side, rather than the Trust's, just from a humane point of view.

Q. A human point of view, yes.

A. CRAIG: A human perspective but it most definitely wasn't. As I say, I can only describe it as institutional bias. That's what it felt like.

A. DAWN: And they were very much against us obviously using the tape that we had mentioned.

Q. Of the CPA meeting?

A. DAWN: Of the CPA meeting, however they failed to mention that they had been listening to our phone calls. So it was very much don't do what we do, do as we say.

A. CRAIG: And obviously that was a factual piece of recording, you know, you can't dispute that. Yet there was other piece of blackmail -- or the other issue that the Coroner allowed to be presented during the trial, the sensitive information that I'm not sure if I can say it or whether I can't.

Q. We don't need to.

A. CRAIG: So that was just unnecessary. We informed the Coroner and the legal teams that this would have a massive impact on my dad's health, my dad's health going forward was completely dismissed. This was a relevant piece of information but she was not allowing it to be framed in a different way. It was coming out as brutal as it could be.

Q. Yes.

A. CRAIG: And I just, again, it just seemed to me that very much erring on the side of the Trust's case, rather than, I shouldn't put it as a case because it wasn't a trial, but the Trust's position.

Q. I understand. The other thing that happened and then I would very much like if I can to move to talk with you both about the recommendations you would like to see made, or the comments you have made on there, is that talking as you have just done, Craig, about the thinking and the compassion behind actions taken following the death of a loved one, I understand that on 21 July of 2014, your father received at home a letter to your mother inviting her to join the board of governors.

A. DAWN: Indeed.

Q. Or some position of that sort; is that right?

A. CRAIG: Correct.

Q. That obviously would have been fantastically distressing to him. Did he receive an apology or did you?

A. DAWN: I think he did.

A. CRAIG: I can't remember.

A. DAWN: I think he did, yes, but I mean how can that happen?

A. CRAIG: Even at the time initially after mum's death, we went to the ward to collect her things and the staff, there was, there's no sympathy/empathy. They just kept

referring to mum as "the body". And I have to say I had to walk out because I was about to lose my temper. That, 24 hours earlier she was under their care, or meant to be under their care.

Q. Yes. That injury recollection also of that day that staff, on 1 March that when you went to the ward, staff referred to your mum as "the body"?

A. DAWN: Indeed, and they didn't really know the process, did not appear to know the process and what we should do next. I think we might have been given a leaflet, I'm not sure.

Q. I think you told us that it appeared to be nobody knew the process --

A. DAWN: No.

Q. -- everything was chaotic and they didn't even have a telephone number for the mortuary.

A. DAWN: That's correct. And around that time, as well, we had asked, my husband had been in contact with the Coroner's officer to see if we could have a full toxicology report at the post mortem.

Q. Yes.

A. DAWN: This was because in my mum's personal diaries she had put that she had kept asking for PRN and for blood tests because she was describing herself, not that she knew what it would feel like but she said, "If I knew

better it would feel like cold turkey, it was almost like I was coming off of the medication."

Q. Withdrawal.

A. At that time she had been, her dosage of Risperidone had been increased, despite the fact that she had some like blurred vision and things like that, which is something that Risperidone causes and she should have been taken off of it or reduced immediately. But when the police officer went to the nurse's station to get my mum's notes for the post mortem, they were given the wrong notes, so the toxicology report was inconsistent because it wasn't the right patient's notes.

Q. Yes. When you were asked, Dawn, in the Inquiry's Rule 9 request, a question along the lines of what do you think should have been done differently for your mum and your answer, I think --

A. **DAWN:** Just everything.

Q. Everything, yes.

A. **DAWN:** Everything. We should have never been at that stage because she was a voluntary patient. When you think how stretched the Mental Health Care is and the fact that mum should have been in there for just three weeks, a quick fix, and had they listened to us or looked back at 2008, that's all that needed to be done. All she needed to be given was the PRN that she was given on that

occasion, I'm not saying it would have worked exactly the same way but they didn't even try it. She was supposed to be there for a three week quick fix. She could have had that, she could have been like in a deep sleep for three days as she was before, and perhaps --

Q. Come through it.

A. DAWN: Come through it. But that wasn't even tried, and I think, Craig, there was an occasion where mum was agitated, I don't remember when it was.

A. CRAIG: Yes, I think Dawn was away and I had come to visit mum one weekend, Saturday afternoon, and she was agitated and there was a temporary bank staff -- no, she was sitting in from the other ward so she had come over. I can't remember even how I started the conversation with her and asked her regarding this particular medication, and she listened to me and she prescribed it. Now, that just -- obviously I was pleased at the time, I thought, "Great, this is a way forward." Ultimately, that was removed, but again, when you think about that process, that is it right that a temporary member of staff who doesn't know mum's case is able to change her medication at will?

Q. And at your request.

A. CRAIG: And at our request, without going through a governance process. I find that, in retrospect when you

think about different things, difficult to accept. At the time I was pleased, I thought mum's getting what she had before and we may get on the right road again.

Q. I understand.

A. CRAIG: But not ideal.

A. DAWN: On that note as well, in respect of a temporary nurse coming in, bank staff or whatever, they were changing the computer systems at that particular time and some were trained on, I can't remember, I think one was called Remedy.

Q. Remedy.

A. And one was called Care something, but they didn't know how to transfer the details or -- because some people didn't have access to the up to date records, so ...

Q. Yes. That was one of the findings of the SI report, that those problems and poor recordkeeping impacted or may have had an impact on your mother's care and treatment because some of it simply wasn't available, for example, some of the notes or records on one or other of those systems wasn't available to bank staff, for example.

A. DAWN: Yes.

A. CRAIG: I think there was also, correct me if I am wrong, example where the records weren't dated correctly, I think there was an entry after mum's death.

Q. I see.

A. CRAIG: Or something like that, I am pretty sure the consistency or the accuracy of mum's record definitely had a lot to be desired.

Q. Dawn, moving please, if I can, to the matters you have listed at page 42 of your witness statement, that you would ask the Inquiry to consider as recommendations for change. We have covered, I think, these; staffing and training, the suitability of wards, the interaction with and between staff and psychiatrists, care plans and treatment and compliance with regulation or regulatory bodies. Before I move to Craig to look at his views and recommendations, is there anything, us having gone through all that we have gone through this morning, that you would want to add at this stage to that list?

A. DAWN: Only if these recommendations are made that it's actually checked that these recommendations are complied with because, from my understanding, the CQC inspected the wards on numerous occasions and I think, I can't even count on two hands how many times said did about ligature points and these were never removed. Had they been removed, or after mum's death, then perhaps people that died the following year would still be here. But it wasn't complied with. I don't know if this is finances, incompetence or they just brushed it under the mat because nobody was checking whether these things were

going to be done.

Q. They weren't.

A. DAWN: They weren't.

Q. I understand, thank you. Craig, you have recorded in two paragraphs in your witness statement on page 12 your views and recommendations and some thoughts that you have and you note the other deaths in Essex that this Inquiry is examining and tell us that you think all the obvious recommendations will already have been made.

A. CRAIG: Yes. To me, this is just, as it says there, there's just zero accountability. I am mindful that a lot of this comes down to budget. It's -- mental health has become more in focus since mum's death, thankfully, but is there a real desire to take these recommendations and others more seriously? That's what I question.

There's a small note in this and it may be harsh, but I'm a bit of a cynic at heart, so apologies. But sometimes I just wonder, it's a bit like battlefield casualties, and this is why how I view some of perhaps the Trust or the Government. On the battlefield, especially in recent engagements that most forces, British forces, have been involved with, the enemy are not trying to kill our combatants, they're trying to maim and injure because the impact, both for the cost of and mentally for the relatives and the Government, especially

the cost, is significantly greater than repatriating one of our forces personnel. I sometimes think it's easier (this is me), it's easier for the trusts and the Government to let these incidents happen because they can't adequately finance the treatment, so it's an easy way out.

That's incredibly harsh and maybe a completely off-centre way of thinking of it, but I can't see why simple instructions, guidance, whatever you want to call them, removing ligatures, cannot be addressed. That is not a significant cost to any entity at all. I can only assume, then, they are quite happy to go through this process of, or allowing people to go through this process.

To Dawn's point, at the Coroner's inquest, where we have had significant numbers of people attending those inquests for exactly the same reasons that we have had to go through and they continue to go through, what other conclusion can you draw? It's just lack of desire, lack of willingness and it's just easy to keep going with the status quo and that's unacceptable.

MS TROUP: Thank you. Chair, I have come to the end of my questions for Dawn and Craig and unless you have any others we can break.

THE CHAIR: I have got none. Can I thank you both very much

for coming. I really appreciate it. I know it can't have been easy.

MS TROUP: Chair, I am reminded very kindly that there is a photograph of Iris that we had planned to show now if you are both happy to go ahead and do that. My apologies.

CRAIG: Happier days.

THE CHAIR: A babysitter.

CRAIG: Two.

THE CHAIR: Thank you.

(1.13 pm)

(Break)

(1.20 pm)

HEARING MANAGER: There are no further questions for these witnesses so we will now break for lunch and return at 2 o'clock.

(1.20 pm)

(Luncheon adjournment)

(2.03 pm)

CHAIRMAN: Yes, Mr Griffin?

ROBERT WADE (sworn)

Examination by MR GRIFFIN

MR GRIFFIN: Before we go any further, may I just check that you can hear me clearly?

A. I can, thank you.

Q. Would you give your full name, please?

A. Robert Ian Wade.

Q. And you are here to give evidence about your son, Richard Wade; is that correct?

A. That is correct.

Q. And today you will be giving evidence to this Inquiry about when Richard first experienced mental ill health in 2007, the mental ill health he went on to experience in 2015, culminating in his admission in the Linden Centre in Chelmsford on Finchingfield ward. Tragically also his death shortly afterwards and matters surrounding all of this, together with the recommendations you suggest the Inquiry should consider making, is that correct?

A. Yes.

Q. Was Richard under the care of North Essex Partnership University NHS Foundation Trust or NEPT whilst a patient at the Linden Centre?

A. He was.

Q. Have you provided the Inquiry with a main witness statement?

A. I have.

Q. Do you have that in front of you?

A. I do.

Q. Is it 50 pages long?

A. It is.

Q. And if we look at pages 46 and 47, can we see that there

is a statement of truth and that you have signed the statement?

A. It is and I have.

Q. And is that statement dated 4 June of this year?

A. It is.

Q. You explain, this is paragraph 2, in that statement that it is based on your memory of events and from your understanding of Richard's records and other disclosure and the evidence placed before his inquest; is that correct?

A. That's correct.

Q. Have you had an opportunity to read through that statement recently?

A. I have.

Q. I think there are a couple of minor corrections to be made. Can we deal with those first, please?

A. Yes.

Q. First dealing with paragraph 32(iv) on page 9, should the reference in that paragraph be to 12 am rather than 12 pm?

A. It should.

Q. And should the reference in paragraph 52(i) on page 13 be to 17 May rather than 17 March?

A. It should.

Q. And the reference in paragraph 148 of the statement, we

can see there reference to the word "abdominal", should that in fact say "abnormal"?

A. It should.

Q. Are there any other corrections that you would like to notify just at the moment?

A. There is one other, the year is stated at 2015, it was actually 2016 and hopefully we will pick that up as we pass through.

Q. Was it the other way around, 2015 should have been 2016.

A. That's correct.

Q. We will find that and we can notify people if we don't pick it up during this evidence. Subject to all of that, is this statement true and accurate to the best of your knowledge and belief?

A. It is.

Q. Thank you. I am going to call that your main statement or just your statement, but in fact you have separately provided something that's entitled an addendum statement.

A. Mm hmm.

Q. Does that contain your suggested recommendations?

A. Yes, it does.

Q. And that refers to a document that's entitled:

"A proposal for a National Health Service mental health patient safety doctrine", which you have also provided to us.

A. I have, yes.

Q. I will refer to that as "the doctrine". Please feel free to refer to any of those documents as is helpful to you. Your main statement, your recommendations, the doctrine all form part of the body evidence of this Inquiry. I won't be asking you about every aspect of them, so please rest assured that the Inquiry will take considerable care to scrutinise everything you have said.

Robert, did you provide a commemorative account in relation to Richard at our hearing in September last year?

A. I did.

Q. In fact, it was the last day, I think, on 24 September.

A. It was, yes.

Q. And I think you were accompanied then by your wife, Linda, yes? And I think Linda is here today, accompanying you today as well; is that correct?

A. She is.

Q. I would like to start your evidence by talking about Richard. Was he born on 13 April 1985?

A. He was.

Q. Your commemorative evidence in September included that he grew up healthy and strong with a sharp and agile mind.

A. He did.

Q. He loved sport, particularly cricket.

A. Very much.

Q. You made a reference to rugby as well but cricket was his main game.

A. It was.

Q. And he enjoyed academic success.

A. He did.

Q. We will talk a little bit more about that and his time at Essex University in a moment.

A. Okay.

Q. Before we move on, is there anything else you would like to say now about Richard. We heard with interest what you said in September, and as I said, we will touch on his time at Essex at just after that. Is there anything else that you would like to tell us about him before we move on?

A. I think I said what needed to be said about him in September, and today I would like to focus on doing this and doing this alone, but rest assured he is very much in my mind, as you can imagine.

Q. Let's move to 2007, please. Would Richard have been 21 or 22 years old, around that age at this time?

A. 2007, I think he was 21.

Q. I want to look at something, to address with you something that you say in your statement about this period.

A. Okay.

Q. I am going to be looking from paragraph 3 of your main statement.

A. Okay.

Q. This is what you say there:

"Richard's mental health problems first arose in 2007 as an irrational fear of motor neurone disease or MND. Despite regular visits to GPs and A&E departments, each giving the same reassurance, he could not free himself from those fears. The only treatments he received were antidepressants. He was deeply anxious, causing him to be restless, pace and lose sleep."

You say at paragraph:

"A mental health home visit team did assess Richard in 2007. They asked few questions and left after suggesting he consult a neurologist. This being contrary to the GP's assessment of his condition being of depressive origins, was not followed. The GP did refer Richard to the same community mental health clinic that made the home visit but Richard declined the appointment. At a later point that year, and if an attempt to break Richard's depressive cycle, we privately consulted a specialist MND neurologist."

So was a private appointment made for Richard to see a leading MND specialist?

A. It was, yes.

Q. What was the specialist's diagnosis?

A. The diagnosis really boiled down to the specialist saying to Richard that, "I am going the tell you that you don't have motor neuron disease, but you are not going believe me, are you?" To which Richard said, "No", his fear was deep rooted. I think behind that the neurologist made the obvious diagnosis that it was, in fact, depression that he had and this was an expression of that depression as motor neuron disease.

Q. Thank you. You describe in your statement how following that visit there was a gradual deterioration in Richard's condition.

A. Yes.

Q. That he was too ill to work and that he was kept at home in the company of a relative or friend.

A. Yes.

Q. And, in fact, is it a feature of the times that Richard had mental ill health that there was close support for him from his family and friends?

A. Yes. We have got excellent family relations. My sister lives a few miles away, so we were able to draw on uncles, aunts and nephews who were more than willing to sit there, they shared all their Christmases, they shared their birthdays and many other things together. So that

was there. He had an excellent circle of friends, they were willing to support as well and of course his brother, my wife and I would take as much of the burden as we could.

Q. You mentioned his brother, that is his younger brother?

A. That's his younger brother, yes.

Q. Can I just check that everyone can hear the evidence clearly? Thank you. Did the deterioration reach a crisis point in around midsummer of 2007?

A. Mm hmm, yes. The conditions were getting worse and worse, we had done the rounds of the doctors, we had done the rounds of the hospital. Along the way it became obvious he was becoming depressive, but they seemed to have no way of getting out of the cycle. Whatever resources they had, they were an antidepressant drug or a visit by a home support team or something of that nature. There seemed to be no way from our conversations with them to escalate it to anything meaningful within mental health. So as we really had been round that cycle many, many times and Richard's anxious state was growing and growing, that reached a crisis point one afternoon, which I think is where you are going to go next with the home visit by a GP or you will do in your time.

Q. Absolutely. Let's move to that now.

A. Okay.

Q. Is it right that the GP prescribed a strong sedative?
A. It is.
Q. For Richard, and what effect did that have?
A. One of the problems Richard had all the way through was that he couldn't sleep. Richard was a very light sleeper and only slept little. He liked working and sleep was something he did, but it was always light. Even by Richard's standards, the sleep had become far too short to sustain him, which of course accelerated the problems that he experienced. On the day that the doctor got there he was pacing, talking, he was most uncomfortable. The doctor gave him a strong sedative and he fell asleep and he slept a long time after that one. That seemed to break the cycle and in doing that, he then slept longer and longer, sometimes hours and hours at a time during the day as well as at night and it was the catching up with the sleep that was really the path to recovery. That's what he needed. That is what he had lost and that is what he got back.
Q. Having had the advantage of the sedative and being able to sleep, was there also a course of private counseling?
A. Yes. After that, my wife contacted -- researched and contacted a local counsellor and that counsellor worked with Richard over a period of time. I can't remember the exact amount of time now, but I don't think that's

important. She worked with him as long as necessary. And he came out of that in a much better condition than he went into the final crisis point.

Q. And, in fact, the way you put it in your statement is that he could pick up the threads of his life.

A. Yes, indeed.

Q. I want to come on now to a comment you have made in your statement about this period. Could you put up, please, the main statement at page 2. That's HJA007877 and expand paragraph 7. I think you have touched on this already, but can we just look at this. It is on the screen in front of you as well:

"Each of the medical professionals with whom Richard consulted at this time gave him appropriate treatment and care within their compass."

A. Mm hmm.

Q. "What seemed to be missing was any route to specialist resources to hasten Richard's recovery."

Now you spoke to a route about breaking out of the cycle. Is that the comment here or is this pointing to something else?

A. No, that one is alluding to it if you like. What that is really saying is that each of the doctors we saw were thoroughly professional, they were absolutely correct in what they did, they were correct in their diagnosis, but

when they come to the point of doing something about mental illness they had nothing in their toolkit. If it were a physical problem they would have antibiotics, they would have some other drugs, they would have a route of referral to a consultant, but that seemed to be completely absent on the mental health side. That didn't seem to come about. And so everything they did was within their compass, in other words they did what they could and they had no more, but what was missing, and as I allude to there, is the specialist resources to assist to Richard's recovery. Now, those special resources in this case turned out to be an injection in the arm to put him to sleep to get him back into sleep patterns, such that he could make his own recovery with his family and his friends around him, supporting him through all of that period and then at the end of it taking a course of counseling therapy that moved him then towards the brightest period of his life and I expect we will come to that later again.

Q. I think this is something of a theme that we might pick up on later on, people working within their own compasses, as you said it --

A. Yes.

Q. -- and not having access to the specialist tools that perhaps would have assisted at an earlier stage?

A. Yes, and from memory I listed them on the second occasion so there is more detail.

Q. We will come on to that again. Could you take that down, please. I am just picking up on an aspect of that, this is from paragraph 15 of your statement that the antidepressants prescribed to Richard addressed the chronic aspect of his condition.

A. Yes.

Q. But it was the sedative he was given during the GP home visit that addressed the acute side and opened the way for a more rapid recovery. That is point you have just been making?

A. It is, although the antidepressants may have worked in the long-term he really needed to get though a short-term crisis and the exit route for that crisis was the injection and the sedative that put him to sleep.

Q. You say later in your statement that the use of sedatives allowing him to sleep was the only effective intervention in his suffering. Is that throughout the whole of this period, both 2007 and 2015?

A. Yes. No, that's the only one that had a marked change. He did on occasion later on try sleeping tablets, but his depression was so far advanced that talking to a friend who is a doctor, he lightheartedly mentioned that he would have needed horse tablets to have had an effect on

him. They simply weren't strong enough to have the effect that was desired. They may have been at the limits of what can be prescribed safely, but they weren't adequate for what he needed.

Q. Thank you. Let's deal with the time between 2007 and 2015. You cover this at paragraph 16 of your statement.

A. Yes.

Q. You say that the period between the two bouts of mental ill health, as you put it, were the most productive of his life.

A. Indeed.

Q. You explain that he returned to academia, he studied an MA in history and a Ph.D. in political science at Essex University?

A. Yes, he did.

Q. And then at paragraph 17 you set out some further things that he was -- actually paragraph 11, this is page 2, you set out what he was able to accomplish. Would you just take us through that. This is the bottom of page 2 and the top of page 3?

A. Yes. While he was at Essex University and having completed his masters, he got involved -- I will take them in sequence, it is easier to follow. Across the whole of that period so these aren't in particular order, he founded and helped found the academic student journal

that they started publishing again. He has a paper which is the first paper in the first edition, so Richard being Richard, he had put himself to the forefront there. That was published and we are privileged to have a copy of that on our shelf at home. He founded, recruited, trained and lead the debating society and team. Essex University at that point didn't have a debating society. Richard was interested in politics, and so he thought, "How can I rope as many people as possible in helping me go the direction I want to go whilst doing them a favour in return?" So he started a debating society that he then recruited, trained and took to competitions. So that he had debating competitions. We had the wonderful privilege of meeting some of that team at his funeral and one young gentleman there, a young Asian gentleman we were talking to, said that he was by nature extremely shy, but having met Richard and been strong armed into the debating team, he ended up after university, not necessarily following his degree, but he became a radio presenter with him own program on an Asian channel in the Birmingham area.

Q. I think you may have told us about that in September actually.

A. It was a wonderful story with that one there. He played for the university rugby club, which give me lots of taxi

duty all round because Richard did not drive, did not want to drive and probably never would drive. That is probably a good thing for all of us. He did many things well but driving was not one of them. He became a lecture in American politics, he has always been fascinated by America and its politics, particularly the lead-up into and out of the 1960s period so he used to lecture on that. That would supplement his income and that was while he was doing a Ph.D.

Q. And, in fact, I remember in September you brought a copy of his book along?

A. Yes.

Q. And you refer to that in paragraph 14. Just tell us briefly about that?

A. Yes, Richard's fascination in politics was not only the Ph.D. but he took that further. He wrote a book called:

"Conservative Economic Policy from Heath in Opposition to Cameron in Coalition."

Which he interviewed many people, Norman Tebbitt and a list of illustrious people that sort of standard are on there. I still have the recordings of those interviews. I can't bring myself to listen to them, but I think there will at some point be an appropriate academic library where they should sit.

Q. You say elsewhere that Richard enjoyed good physical

health?

A. Yes he did, he was as strong as an ox.

Q. It sounds from your evidence as if in this period from 2007 to 2015 he was thriving for much of that time?

A. Sorry he was?

Q. Thriving?

A. Yes, he was.

Q. I am afraid that does now bring to us 2015 and the reappearance of the symptoms.

A. Okay.

Q. Did his fear of MND first reappear in early May 2015?

A. Yes, round about that time.

Q. You cover this in paragraph 17, in fact you give it a date, 4 May.

A. His depression has started to become evident before that in very small parts, but again it accelerated away. So finding the date of the transition is very difficult to pin on that one.

Q. But from around early May?

A. Yes, that would be reasonable.

Q. You then describe in your statement the period between 4 and 12 May.

A. Yes.

Q. When Richard saw the GP on various occasions and attended Broomfield Hospital A&E, and during this period was he

prescribed diazepam, sleeping tablets, antidepressants?

A. Yes, but different things with different doctors. In the round, yes.

Q. Did he in fact see GPs from two different surgeries, his own GP in Essex and your local GP in Suffolk?

A. Yes.

Q. That may become relevant a little bit later on.

A. Okay.

Q. Let's just be clear, at this time in 2015, was Richard living in Essex and your family home, where you were, was in Suffolk, correct?

A. Yes. Richard lived in Chelmsford and he commuted in to London on a daily basis, and then he would come and visit us as often as he reasonably could in Sudbury in Suffolk.

Q. Thank you very much. Now, the medication that he was prescribed at this stage, did that make any difference to his condition?

A. None at all.

Q. As far as you could see during this period, was there any thought given to a longer term care plan?

A. No.

Q. During this time did any doctor consider or discuss with you or Richard, as far as you're aware, the question of a possible admission?

A. No.

Q. So this is what you say in your statement at paragraph 245:

"Identifying the sequence of the phases of Richard's deterioration in both episodes" -- so that's 2007 and 2015 -- "of his illness, it appears that the second phase, or pre-crisis, was the point at which decisive intervention would have been most beneficial."

A. Yes.

Q. "And yet in the decisions and prescriptions of both GPs and A&E (they) were ineffective in preventing the crisis phase that followed."

You add in a paragraph afterwards, 247, that:

"... in the case of Richard, the routes for prompt escalation either did not exist or were not used. His progression into crisis was inevitable."

You say in the next paragraph:

"Having considered Richard's decline into mental health crisis on two occasions, and repeated failure to act effectively during his pre-crisis period, it is clear that Richard did not receive adequate treatment."

So I would like to just take stock and make sure I understand the importance of what you have said there, please. Are you saying that a key issue in Richard's case was a failure to act at an early stage

pre-crisis, and in doing so to avert the development of the actual crisis itself?

A. Absolutely.

Q. Are you saying that the mechanisms were not in place at this time for this to happen?

A. They were either not in place or they were not used. I do not know which.

Q. In fact, is this one of the areas of the doctrine that you have put forward seeks to cover, and we will come on to that?

A. Yes.

THE CHAIR: Can I just ask, you pointed us in the direction of the sedatives that were given to him in the earlier phase. Do you believe that that is one of the things that would have helped at this stage? Or do you not have a view about what that earlier intervention would have looked like?

A. I have given some thought to that point. I don't think it is important what the treatment is specifically. What is important is that the meaningful intervention comes before the transition from the first phase of the mental illness taking route, before it then accelerates away and that goes into the crisis that follows. It is the aversion of that second part. In Richard's case it was indeed the sedative. Now there is an aversion to giving

sedatives outside and I remember in the news many years ago there were cases of sedatives being used just as liquid cosh to put patients out so that they wouldn't be a trouble during the day and the night, and quite a campaign led on that and the consequence of that was that the idea of using sedatives on patients was frowned upon. But it was right in so far as those for whom it was not necessary but it seems that it was no longer available for those that it was necessary for. From that part there it means that for those for whom that type of treatment is appropriate, if it is not available they will inevitably make the transition from the non-crisis phase to the crisis phase and there is nothing to stop them because the illness has taken over.

MR GRIFFIN: I would like to move now to 16 May. This is the assessment. Was that a Saturday?

A. Yes, it was.

Q. You describe in your statement that Richard's next contact with medical professionals was the Suffolk Mental Health Crisis Team at your home on that evening, Saturday 16 November.

A. That's correct, yes.

Q. Now did they work as part of the Norfolk and Suffolk NHS Foundation Trust, as far as you are aware?

A. They did.

Q. And did an assessment take place, in circumstances we will come on to in a moment, by an emergency mental health assessor?

A. Yes, it did.

Q. And let's, if we need to, let's refer to her as the mental health assessor.

A. Okay.

Q. Did she attend with two police officers?

A. She did.

Q. This is from paragraph 17 of your statement and 22. Now was this the only time that Richard had an assessment of this type?

A. Yes, it was. He had seen the mental health team visit in the previous one but he didn't have a full assessment on that.

Q. Now from paragraph 22 in your statement you describe what happened at this stage. In essence, was it this? Was Richard pacing outside the family home and did he refuse to reenter, for example, for dinner?

A. That's right.

Q. Was the assessment therefore carried out in the street outside your home?

A. Yes, it was.

Q. What was the temperature like at this time, do you remember?

A. It was a May day, so at that particular point in the day it wasn't too uncomfortable. That, I think, we will come to shortly.

Q. Was he in fact outside for several hours?

A. He was, yes.

Q. And did the temperature drop during that time?

A. Yes, it did.

Q. And did you have to take action, for example, sending out warm food and clothing?

A. Yes.

Q. What involvement did you and your family have in this assessment that was taking place outside of the house?

A. None whatsoever.

Q. Were you, however, able to give the mental health assessor background information about Richard's illness?

A. We were, yes.

Q. A decision was made to take him to a mental health facility. Were you involved in that decision at all?

A. Yes, we were. It was clear that he needed to go to a mental health facility and the obvious one for the mental health nurse, the assessing nurse at our house, was to use the Trust for which she worked which was Norfolk and Suffolk, but they wouldn't take him. They thought that he should go to Essex. He should go to Essex because although he was in Suffolk visiting us, his GP was in

Essex and so they should take him. That formed the basis of a long delay through that evening before he finally got an admission.

Q. So you say you were outside or he was outside for hours. Was much of that time actually taken up in working out where he should go?

A. There was two big chunks, one of them was giving the nurse the information that she needed to support the decision that she pretty much had already come to. A very small part was then deciding what type of admission it should be, perhaps we will leave that.

Q. Well, in fact, ultimately was the decision that it should be a voluntary admission?

A. It was and we had a strong influence on that on the guidance from the nurse, which I think was the correct decision in itself.

Q. Before we move on to Richard being taken to the Linden Centre, I just want to ask you about the kind of information you were able to give to the mental health assessor because this may become relevant.

A. Okay.

Q. You explain in your statement that you gave all the relevant information that you could and you say this, this is paragraph 22, "Nothing was left out."

A. Everything she asked, everything that we could think of,

we told her.

Q. And you had, and this is at 22 (xi) on page 6, "We covered the issue of suicide." Now do you recall, and I am sorry to ask you this, but do you recall what you informed the mental health assessor of in terms of suicide?

A. We told her that he had discussed taking his own life with his aunt, my sister, and that he wanted her to take him to the *(redacted)* bridge so that he could jump off at the centre mark of it. My wife is Welsh and I am English, and in Richard's mind the way he thought it would be so that we could not determine which country he had taken his life in. So he wanted to go to the *(redacted)* bridge. He also had very good family links into Wales, as strong as those in England just more remote, and he would have been -- it would have been a very jumbled mind making not the best of decisions but something that seemed sensible to his troubled mind at that time.

Q. But this is obviously something he had thought about and articulated quite clearly.

A. He had thought about, articulated, he had by this stage probably researched something about on the internet and we are certain that at a later point that he had.

Q. And was that information that you passed on to the mental

health assessor?

A. Yes.

Q. You say this at paragraph 85 of your statement as well, page 19. You say:

"On 16 May" -- so during this session as I understand it -- "I gave the MHA a warning that if Richard became overwhelmed by his suicidal ideations and there was a flaw in the safety policies and procedures in a ward, he would quickly identify it."

Now is that correct? Was that also information that you provided to the mental health assessor whilst Richard was outside the house?

A. I did, yes.

Q. Thank you. Did you become aware that a bed had been secured in a mental health ward ultimately and that Richard would be admitted?

A. Yes. I would like to explain a little around that selection process.

Q. Yes.

A. The selection process wasn't the trust's -- there were now two trusts negotiating over Richard, North Essex and Norfolk and Suffolk, but they weren't negotiating to have him, they were negotiating for the other one to have him. They didn't want him. The saddening part of that is, in truth, both had beds available. Neither wanted to fill

it. So the nurse, who I have great sympathy for, was just left to hang out to dry in our house while they fought out what they wanted to do.

Q. You say in your statement, this is paragraph 31:

"Why was Richard not simply taken to the nearest available and most appropriate facility?"

And is that the strong feeling you have now?

A. It is very much. I think I go on to say that if they needed to transfer him subsequent to that, they could make any financial arrangements between themselves and it would surprise me if they haven't got such a facility. What I couldn't understand is if neither of them wanted to and all of those counties are in East Anglia, at what point is that a National Health Service? Well, it wasn't, they were independent health services each protecting their own interest at that time.

Q. Thank you. And I think the situation outside the house was made even worse by a troubling allegation that Richard made against you.

A. Correct.

Q. Did he accuse you of trying to kill him and did it quickly become apparent that there was nothing to answer for, but at least did it demonstrate the state of mind that he was in at the time?

A. Yes, this is more that -- I think it was I wanted to kill

him, but I don't think it makes that much difference to the type of accusation made. That accusation was made and the police officer that it was made to -- I knew nothing about this and I was walking around trying to arrange things and trying to help the nurse get the arrangements correct for getting Richard into appropriate care and as I walked through the hall, the policeman suddenly and very forcefully said, "Your son says you want to kill him." I must be honest that took me aback. That was an utterly shocking and awful thing to hear. I think with a little bit of reading the room and a touch of sensitivity, as much as he was compelled to deal with the issues, I don't think it would be difficult to come up with a thousand and one better ways than that.

Q. So more compassionate approach, or more understanding approach, would have been in order.

A. I think if he is an experienced police officer, and he was, he would have read the situation outside and Richard's condition, he would have had a good idea of what type of family it was he was dealing with, the people that were there and if it was at all credible, and balanced his approach on those factors. I don't think for a minute he shouldn't have challenged me in some way because that's a serious thing for someone to say and if he doesn't follow up on it and it leads to a consequence

later that has its own problems. So yes, by all means follow it up but think, be considerate, be compassionate and be thoughtful to circumstance, context and all that you see around you, because that, after all, is what they should be trained for.

Q. Thank you. And in fact was there another repercussion of the allegation that Richard had made, was that in fact, as you say in your statement, that it made it next to impossible for you fully to participate in identifying the best course of action for Richard?

A. Well, it would and it did. The accusation having been made, the nurse has to take that into consideration in putting in her thoughts, and what she advises a degree of protection for Richard such that if it turns out to be true, that can be thought of and considered. So yes, it somewhat cramped my style.

Q. We are going to move off from this time in a moment. Before we do, I would like to look at an aspect of your statement, please. Could you put up page 6 of the statement. This is HJA007877 and expand (xii) and (xiv) at the bottom of the page. In fact, can we see at the bottom "Our one concern"? So this is at this stage whilst this assessment is taking place outside your house:

"Our one concern was his safety, and my wife

asked the MHA: 'will he be safe?' (and) her reply: 'Yes'."

Did you hear that as well?

A. Yes, I was standing there.

Q. Do you recall how you and Linda felt on hearing that?

A. I think relief is the main thing. We knew that he was in a desperate situation. The behaviour that he was exhibiting was completely alien to his normal nature in every way. We were deeply concerned for his safety and what might happen to him and when we heard that and knowing that he would be going to a specialist hospital that should be able to recognise and treat his condition and know that he will be safe and, therefore, able to recover and maybe this time the, sequence of events of the motor neuron disease having happened twice, we would have to put a longer term programme in place for and with Richard. But that was a relief in itself.

Q. Can you take that down, please. We are going to move on now, Robert, to Richard's admission at the Linden Centre. Before we do, is there anything further you would like to raise about the time Richard was assessed outside the house and what happened at that stage?

A. I think we have covered all the key issues that go with that one. Sorry, may I just say one thing? The nurse at that point did come up for a lot of pressure later on in

other investigations and the Inquiry and the questioning of me when I talked to the Trust, which I think all of it was wholly misplaced, and I think she managed a difficult situation to the best that her experience and ability allowed her.

Q. In fact, we are going to come on in a moment to another difficult situation involving her, aren't we?

A. Okay.

Q. Just coming on then to Richard's admission at the Linden centre in Chelmsford, was he admitted to Finchingfield Ward?

A. Yes, he was.

Q. Now that, we understand, is an acute adult in-patient ward?

A. Yes.

Q. Was this Richard's first ever admission to a mental health ward.

A. It was.

Q. And as we have established this was an informal admission?

A. Indeed.

Q. Did he arrive for admission procedure at about 12 am and did he enter the ward at about 1 am on Sunday 17 May as far as you are aware?

A. I think those times are about right from the documents I

have.

Q. Did you and Linda also make your way to the Linden Centre but a little later on as we will hear?

A. Sorry, I couldn't quite here that.

Q. Did you -- so Richard has gone and been admitted in the very early hours of Sunday 17 May 2015?

A. Yes.

Q. Is it right that you and Linda also went to the Linden Centre but that was a little bit later on?

A. That's correct, yes.

Q. If at any stage I say something that you can't hear, please make sure to stop me as you just did, thank you. Now what I want to come on to first of all is what you describe in your statement, it is an issue between the mental health assessor and the receiving staff nurse on the ward. Have you learnt that this issue occurred at the time of his admission to the Linden Centre? So the mental health assessor from the Norfolk Suffolk Trust, as you have described, and the admitting nurse at the Linden Centre from NEPT, let's refer to the admitting nurse as the staff nurse. Was the issue, as you understand it, that the staff nurse refused to accept the mental health assessor's oral statement and can you just explain a little bit more of your understanding of what the issue was at this stage.

A. Okay. While at our house the mental health nurse took copious notes. So our expectation is that those notes would have gone down and that would be part of the handover procedure.

Q. Were they handwritten notes?

A. They were handwritten notes, yes.

Q. Thank you.

A. Now, upon the admission, she tried to, as I understand it, and this is from two sources, one is the documents that I have seen and the other one is from comments from -- I will just see how you refer to the DI.

Q. So the detective inspector, we will hear that there were two criminal investigations and this is the detective inspector of the first --

A. Yes, it is the first of the two on this one. The DI not the DCI in this case. When we spoke to him they were doing the first of the corporate manslaughter inquiries into Richard's death. He intimated to us that it was clear that the handover process had been fractious and uncomfortable in what happened. So the nurse taking Richard down wanted to do an oral handover, as you have said. That was not acceptable to the staff nurse as the admitting professional. There was back and forth, it seems, about who should then enter it into their system and it ended up with the assessing nurse from Suffolk

having to try and enter the data into Essex's system, even though the admitting nurse was there. So at this point the information is supposedly going in, but what is unusual is if you read the statements that I have managed to acquire that were taken as the interview statements that led up to the serious incident report, of the staff nurse that was the admitting nurse, she then claims in her statements that during the early hours of the morning she entered all the data herself. So it's very difficult to work out who did what and when. But there was a disagreement, I don't know at what level and I don't know where blame, if any, would lie because I was not there and that is not in any of the records, but certainly the DI felt uncomfortable wit the way that that was done.

Q. And would this be another example of a mismatch potentially between two different NHS areas, Norfolk/Suffolk on the one hand and Essex on the other, or do you think this was more of a personal things?

A. Like another piece of evidence we will come to I think it's possibly and maybe probably both.

Q. Thanks you. From what you have learnt subsequently, do you believe that the information that you gave to the mental health assessor about Richard's suicidal ideations was passed on to the staff at the Linden Centre?

A. I think the straightforward answer to that is no, not all

of it was handed over, but what was handed over, one must then ask the question was that sufficient? I suspect you will come on to that a little bit later as well, or I can expand on that now if you wish?

Q. Well, why don't you expand on it briefly now and if we need to go further we can.

A. Right. The question is one, to my mind, not of what information were they given but did they adequate information to manage Richard's condition safely? Now my opinion on that is yes, not just because I'm Richard's father but because if you look at the requirements in the Trust documentation and you map what they actually said they had to those requirements, it was more than met. But that's not just my opinion. There was another doctor, yes, and his name is on here as the consultant psychologist, wrote a report on behalf of Essex police as an independent report, and when he wrote his report, there is a copy there somewhere, that he made it absolutely clear that they had obtained all of the information that they required to manage Richard's condition properly.

Q. We are going to track that through, for example, with the question of the level of observations that was set. So that will illuminate that in a moment. One of the things, just going back to the time when the mental

health assessor was presenting her handwritten notes and whatever happened at that stage, I just want to refer to what you say in your statement. This is paragraph 38. You expressed your, "huge concern that their professional focus was not on prioritising", Richard's needs. And you raised the question of a friction in the acceptance and admissions process and whether that led to poor judgment. So that's paragraph 38 and also paragraph 241. I just wanted to ensure that we have on the record those concerns that you have raised in relation to that stage of the admission.

A. Friction normally between people frequently leads to competition and competition means somebody has to win, but the person that lost was Richard.

Q. Thank you. Now you describe next that after he was admitted, Richard was assessed by a locum doctor. Can we refer to him as the locum doctor?

A. Yes.

Q. You raise concern in your statement that he was only a locum doctor. This is paragraph 240. Could you just explain a little bit more what the nature of your concern was, 240, it's page 44.

A. Okay, on the very first raised question I raised there:

"Was the locum doctor who assessed Richard sufficiently experienced in mental health practice?"

I do have an answer for that one and the answer is in my opinion, no. The locum doctor, I did look it into his background a little bit, had been trained in St Petersburg in Russia. He was not a full member of the Institute of Psychologists, he was an associate, and yet as a locum doctor turning up to make a full assessment on what type of treatment was necessary, he was effectively wielding the power of a consultant since there was no one senior there to challenge him. I can't understand why you would take a locum doctor, who isn't fully experienced in the craft that he wishes to perform, and make better and stronger decisions. In fairness to the doctor and in line with the report by the chartered psychiatrist, he did indeed elicit the necessary information from Richard to make a good decision. It is what he did with the decision where things went wrong, and that was on the level of the observations that Richard was placed on.

Q. We will come on to that in just one moment.

A. May I make a further point? That as a locum he would not have known precisely what all of the practices and how they were performed inside that hospital, so how could he have given good guidance of what level of observation to give, if he wasn't experienced as a full psychiatrist, as a member of the appropriate institute or familiar with

the hospital.

Q. So a key question in your mind is was the staff sufficiently senior and experienced to be conducting this assessment at this stage?

A. In the case of the doctor, yes.

Q. We will come on to the level of observations that were set in just a moment. But what I want to deal with now is the nature of the search that was conducted of Richard, and we know that there is an issue about a failure to remove dangerous items.

A. Mm hmm.

Q. I want to ask you about the items that Richard was left with after his admission to Finchingfield ward. I am going to ask that a part of your statement is put on the screen to address this. Could you please put up page 10 of the statement, HJA007877 and expand paragraphs 36 to 37. This what you say here:

"The search of Richard's possessions was cursory at best; leaving Richard, known to have suicidal ideation, with shoe laces, electric cords, razors, scissors and his dressing gown cord (with which he took his life)."

A. That's correct.

Q. You add this:

"This search was found to be inadequate at

Richard's inquest, forming the basis for a prevention of future deaths instruction to the Trust by the Coroner."

A. Yes.

Q. To be clear Richard was allowed to retain a dressing gown with a cord on admission to the ward?

A. Those items were still in his bag when that bag was returned to us after his death.

Q. In fact, you say later in your statement that only one thing was confiscated from him which was some deodorant spray.

A. That's right.

Q. That was even though some of these items were also considered to be what they term contraband, the razors and the scissors, that it made clear that the list of contraband is not exhaustive, and it is also made clear that anything that a person possesses that they intend to harm themselves or others should be removed.

A. That's correct. If I could just expand on that a little. There is a meaningful and profound difference between the spray and the other items. If you read the documents, the spray comes under the classification of those items that can be used to harm staff. So they removed that from him. What they didn't remove were the things with which he could harm himself. The list that you referred to which is the advisory one, also hangs in the area that

the searches are taken. That list, there is a list of examples that clearly states they are there as examples, that are taken pretty much as *the* policy, and it is even written as if that is the policy in the serious incident report. And so the serious incident report was written by a very senior member of the nursing team, and that person is presenting it as if it is policy when either he knows it isn't, or he knows it is and he is saying it anyway, and I don't think either of those two positions are good in my mind.

Q. In fact you just referred, we know that there was the inquest, obviously. We will come on to the investigations.

A. Of course.

Q. There was also something, an investigation that led to something called a 72-hour report; is that correct?

A. Yes, that is right.

Q. That is dated 14 September 2015, according your statement. Was one of the two recommendations it made that staff receive refresher training on security checks and patient belongings? This is paragraph 123 --

A. I am just getting the record report now, so I can check.

Q. If you look at your statement, it's page 25 and paragraph 123. Do you see that, at (i) there is the reference to the 72-hour report.

A. Page 25.

Q. At paragraph 123, two investigations the 72-hour report, can you see the second of the two recommendations --

A. That's the one where there is the mistake I couldn't remember. The date we received the report was on 14 September 2016, not 2015.

Q. Thank you very much.

A. That was caused by an e-mail that I received from the Trust, where this dates the report as -- the first time of the appearance of the report in this train of e-mails is on 20 May 2015, which would indeed put it in the 72-hour framework. It seems that it was first given to the gentleman that led the interface with us as a family in 2016 and he then passed it on to us. I have several problems with that, in that we had a meeting with the Trust on 5 August 2015 and at that time we were not told this report existed.

Q. So it is right there's an issue either with the timing, the date of the report or with failure to disclose it in a timely manner to you?

A. One or other and again both are possible.

Q. Thank you. As you subsequently learnt, can we see what one of the two recommendations actually related to. So if you look at 123, do you see (b) there, that staff receive refresher training on security checks and patient

belongings. I just want to trace this through, and you have also made reference to a serious investigation report. We will touch on this later, but it is probably right to know, right from the beginning, that you take issue with various aspects of this report?

A. Yes.

Q. This is from December 2015 as I understand it from your statement. That includes, and this is paragraph 164 of your statement at page 26, that includes that there appeared to be a lack of robustness in the searching. 164?

A. Correct, yes.

Q. So both of the investigations conducted, immediately after the death, also reached conclusions of concern in relation to the failure to take dangerous items from Richard?

A. Yes.

Q. In fact, in your statement you described the failure in relation to the search as best described as a failure in policy.

A. Mm hmm.

Q. Can you explain what you meant by that?

A. Can you refer me to the paragraph, please, just to pick up the context?

Q. Yes, it is paragraph 174 at page 33, just at the bottom

of the page.

THE CHAIR: Did you say 173?

MR GRIFFIN: 174 right at bottom.

A. There was a lack of robustness, but there were several things. The policy itself outlines clearly what should and shouldn't be done. What is absolutely clear is that the policies aren't followed and neither are the policies understood by the staff. That's not just true of this policy, it seems to be true of every policy that I have come across. Each and every one has been misapplied in some way or other. Sorry I am just trying to gather my thoughts here and get this part right. The people doing the search go by the convenient list that's placed just in front of them. They do not seem to have an understanding of what the policy is. Now, supposedly they are trained on it, clearly they are not. Now, if you look at all their policies, their policies are thick, complex and whatever you are doing, you have to know where that is in the policy to go there and go and get the advice that you are seeking. But then you don't know it's there because you haven't read the policy or been trained properly. So it is a policy failure in that the policies are monolithic documents that I would suspect for the people doing those particular jobs and the pressures that they have in doing their jobs, they are

never going to get the time to read them and fully understand them. It is that second part. So their policies fail.

Q. Can I just make sure I have understood what you are saying.

A. Yes.

Q. So this is an issue of policy and what you are referring to here is trust policy?

A. Yes.

Q. It is an issue of policy here specifically in relation to search procedures, but you say in fact it looks as if it is a wider problem as well, beyond just this policy?

A. Yes, I would say it's an entire practice of the trust. Maybe I will expand on that a bit later.

Q. It is an issue in relation to staff adherence to policy.

A. Yes.

Q. To the clarity or brevity of that policy?

A. Yes.

Q. And to training or lack of it in relation to the policy?

A. Yes.

Q. Does that cover all of those points?

A. If I were doing that job, if I were expected to read those policies, go on the ward and do them, I wouldn't know how to do it.

Q. I am about to leave this topic of the search Robert.

Before I do, is there anything else you would like to say or raise about that aspect of Richard's experience?

A. There is another aspect on one of the statements in the three-day report, but I think that would probably come up in another section. If not, I will raise it at the end.

Q. Okay that's fine. What I want to do now, please, is come on to the question of observations and risk assessment. You have already adverted to this previously. You explain in your statement that following the Examination by the locum doctor a meeting was held to determine, amongst other things, the level of observations that was to be applied to Richard. Have I understood that correctly?

A. Sorry, once more?

Q. I am going to say that again. If there is an ongoing issue, we may see if we can put up the volume of the microphone. You explain that following the Examination by the locum doctor, a meeting was held to determine, amongst other things, the level of observations that was to be applied to Richard. Have I understood that correctly?

A. Yes, you have.

Q. What kind of meeting do you understand this to have been and for what purpose other than specifically to fix an observation level?

A. Right. The meeting, as I understand it, and what the documents suggests go on is not much more than people sit in a room and they talk about what they are going to do. I am not aware of there being a structured methodology to that meeting in terms of a flowchart or anything of that that was used because there was nothing like that in the records that I have been given or I have seen.

Q. Is this what is sometimes referred to as a multidisciplinary team meeting or do you not know?

A. I don't know about multidisciplinary team meetings. If is such an official sounding meeting, it was an unofficial and ad hoc version of it.

Q. Thank you. You explain, this is from paragraph 134 of your statement, you explain that the decision reached at this meeting was for level 2 observation -- we will come on to that in a moment.

A. Yes.

Q. And you explain this means four observations an hour. And you separately explain in your statement that staff have explained in various interviews that level 2 observations were the standard for new admissions?

A. They have, but I disagree with that from their policy documents.

Q. The Inquiry has received evidence from EPUT, so the successor trust, concerning the different levels of

observations at that trust.

A. Okay.

Q. They start at level 1, which is general observations, which involves knowing the patient's location but without the need to keep them in slight. They then include enhanced levels from 2 to 4. The minimum of the enhanced levels, as we have been told, is level 2 or intermittent observations, where it is necessary to check a patient a minimum of four times an hour. It sounds as if that is the level that you are talking about here, that was applied to Richard, is that --

A. The level 2 was applied, that's correct.

Q. Then there is the level 3, which is sometimes referred as continuous within eyesight. So this is a more enhanced level, where staff are allocated to each patient and the patient must be kept in continuous eyesight. Then there is an even more enhanced level at 4, which is continuous within arm's length where staff are allocated to observe a patient in close proximity.

A. Yes.

Q. I think we are at least concerned with levels 2 and 3. Is that right?

A. I think those are the appropriate two for this, yes.

Q. We will come on to this in a moment, but I have just described level 3 at EPUT. Does that actually equate to

level 3?

A. Yes, it does.

Q. Given what was known about Richard, what is your view about observations being set at level 2, so a minimum of four times an hour?

A. If I go back to the point of the settings of the levels, that is the policy documents do not say that the standard observation level is level 2. It is not in their documents. What the documents for their policies actually say is that the appropriate level should be applied on the information that is known. In a separate document it says that if the patient -- that the big warning flag, if you like, is suicide and it was clearly stated and it was on all the documentation of the Trust that Richard was suicidal. The Trust and even what I classify as the better nurses within it, in the communications that I've had, misunderstand that policy. They seem to have very fixed, this-is-what-we-do attitudes, and are incapable of changing from it. I will give you an example of that, one particular staff nurse, and it is on the list but I won't refer to it at the moment, came in in the morning and said she was shocked that Richard was on level 2. But the Trust is so inflexible, that even though their policies state that she has the authority to increase the level of

observation, though not decrease them, which seems sensible, she didn't do so. But she had the authority to do so. That is another point that is taken up by the consultant psychiatrist with the police, that they are inflexible in the application of their policies. So they are right at convincing themselves that level 2 was the one they always did. They did not go to level 3 although they had the power to do so. I think that in going to level 2, with Richard known to be suicidal and letting him have a shower is a critical part of how he took his life.

THE CHAIR: Can I just ask why do you say they were right or in their own minds they were right to put him in level 2?

A. Because they have absolutely convinced themselves their standard practices, the things they do day-to-day, are in fact what the policies are. Whereas the policies don't say what they think they do. They do not seem to be aware of their own policies.

THE CHAIR: So you say it is a matter of habit that they put people on level 2?

A. I think that would be a reasonable way to express it, yes.

MR GRIFFIN: You say elsewhere in your statement that in your view Richard was at immediate risk, and you explain that NEPT should have taken a more proactive approach to his

care?

A. Hmm mmm.

Q. Having regard to his suicidal ideation and as directed by its own policies?

A. Yes.

Q. And they should have immediately placed him under one-to-one observations?

A. Yes. If I may point out a flaw in their thinking on level 2 observations. It is the observations are four times an hour, which leads everyone to go that would be every 15 minutes. No, they should be done randomly and the Trust is right in that they do do them randomly, but the idea of doing them randomly is that the patient never knows when they are going to be observed. In other words, they don't know when they are not being observed, they can't be certain of it. But since they had given Richard unfettered and unsupervised access to the bathroom, Richard would have known at that point that no one was going to disturb him, which completely nullifies their thinking in using random observations because they have cancelled out the randomness by putting a safe period into it.

Q. What do you think would be different in if Richard had been on a more enhanced level of observations on Finchingfield Ward?

A. All the information that follows would not be taking place, none of it. Would Richard still be alive today? I would hope so. Richard was ill on two occasions with exactly the same thing. So that's the start of a trend. So it is feasible that he may have had to manage that for the rest of his life and we have discussed that as a possibility between us. But we never got to that point. They didn't put him on level 3, they put him on level 2 and as I warned the nurse the night before, if there is a flaw in your processes, he will see it, and he did.

Q. You say at paragraph 90 of your statement that Richard would be helped through his crisis and survived.

A. Yes.

Q. And with proper care and guidance, have found a way to live a fruitful life.

A. Indeed.

Q. Does that accurately summarise the significance, in your eyes, of setting the wrong observation level?

A. Correct.

Q. Robert, I am going to move on to a new topic in a moment. Before I do, is there anything else that you would like to raise on the issue of risk assessment and observation levels?

A. No, not at the moment.

MR GRIFFIN: Chair, it is quarter past three. We've been

going for an hour and a quarter. I wonder if now might be a convenient moment for a ten minute break. That will take us to twenty-five past three.

(3.15 pm)

(Break)

(3.28 pm)

MR GRIFFIN: I would like to move on to ask you about the extent to which staff involved Richard in his own care at the Linden Centre, even for the short time he was there, and also the extent to which the family was involved. I would like first to see what you said about Richard's care management and plans and I am going the turn to paragraph 70 of your statement. What you say there is that:

"An undated and unsigned care plan was shown to us, but as far as we are aware, Richard was not involved in its creation, the Trust claiming that he was too compliant."

What did you understand by that term, "too compliant"?

A. Okay. The care plan that we were shown was to the first two of three pages. The original one did not have a third page, so we did not have a signature and date or an identity. A third page did turn up some weeks later, which surprised me because I don't see how the document

could be separated, but it did turn up some time later when we kept pressing for it. When you read the care plan, it's just completely generic in its terms and if it was trying to do anything for an individual, it just didn't do it, and besides, if you spoke to Richard, you would remember it. He had the knack of being in your mind and remembering him. In what they wrote there was none of his voice, and his voice would have been there had he spoken, had he had the chance to speak in fact. So we challenged that in that there was nothing in his voice, and it was clear that they hadn't seen Richard when they developed this care plan, which they accepted on the basis that he was too compliant. The idea being that because he was so ill and because he would just do everything he was told, whatever he said would therefore be meaningless and of no value to the care plan. So I asked the obvious question, and that is how non-compliant must you be before you get a care plan? And I have never received an answer to that obvious question.

Q. To what extent was the family involved in decisions relating to Richard's care, again for the short time he was on the ward?

A. Not at all. We did try to contact the Trust in the morning, my wife called them, I think about 7.30. I think the times are in here somewhere, called early, and

they promised to call back. They didn't call back so she made another call. We had no chance to make any input at all on the care plan. We couldn't even find out how he was.

Q. Do you think in total, you say somewhere in your statement, that he was actually on Finchingfield Ward for no more than 12 hours in total?

A. That's right.

Q. Is it right that when you phoned the Linden Centre on the morning of 17 May, you were told that Richard's phone battery was drained, that he had asked for a charger, but that none was available?

A. Yes.

Q. So were you able to talk at any stage by phone with him whilst he was at the Linden Centre?

A. No.

Q. In fact, was the last time that any of you spoke to him during the time outside your house on Saturday the 16th?

A. Yes. Well that would be true for me because I went out with him, but withdrew when it was clear that it wasn't going in a good direction. That's when I left him with a neighbour, a really sensible man, he just managed it beautifully till the police got there. My wife only saw him in the house before he thought of going outside and my second son would only have seen him before he left to

go back to his room.

Q. Thank you very much. Can I now ask you about a plan to move Richard out of the Linden Centre, and I would like to look at the part of your statement where you address this. Could you put up please page 20 of the statement that's HAJ007887 and paragraph 94. You say this:

"We had no immediate concerns on the evening of 16 May beyond what one would expect for a son and brother; we were too exhausted and needed sleep for the coming day. It was due to lack of information from and response to my wife's call to the Linden Centre that we started to have doubts about the Linden Centre."

That's the call you just referred to?

A. Mm hmm.

Q. "An internet search on the morning of 17 May revealed many poor reports and serious concerns regarding safety and treatment, and so we formulated a plan to move Richard to a safer location."

So your concerns were raised, both by your own experience with the Linden Centre, and what you had been able to access online; is that right?

A. That's correct.

Q. Could you go over the page please and expand the next two paragraphs?

THE CHAIR: Can I just ask one thing?

MR GRIFFIN: Yes, of course.

THE CHAIR: At what time did your wife phone the Linden Centre?

A. The first one was about 7.30, the second one was about 9, 9.30 something like that, so a while later.

THE CHAIR: And you have criticised, or suggested, that you were not engaged in any way in the care plan that night before. Had you been, what would you have said? What would you have asked them to do?

A. Well, I think the first thing that would come out, given that their observation levels were inappropriate for someone with suicidal ideation. For example, on the admission policy, when they are going in and in the suicide policies, that the danger points should be recognised as those when someone first enters, and if they are unknown to the Trust, both of which were true of Richard at that time, as well as all of the other suicidal ideations that sit on top of it. So those two factors were in breach of their own policy as well. So I think the key thing that I would have been looking for was that they were close to him, knew what his behaviours were and got to understand the troubles that he had, particularly in terms of motor neuron disease, because apart from mentioning it in one or two documents, nothing was done around that at all and no record of any way of

trying to calm him down about it. Now the reason on the previous example that you showed as to why we were so exhausted by the time Richard left, was for the two weeks as the motor neuron disease got the better of the depression, it became the prominent concern on his mind. We spent massive amounts of time trying to talk him down and calm him around that motor neuron disease. The concept and the idea that he could have got in a police car, be taken to another location, walk in and be utterly calm about something that had denied him sleep for weeks or months to the point of crisis all the way through, and you just lie down and have a goodnight's sleep is a patent nonsense. So that's where I would really be starting from. They had completely the wrong end of the stick and in many ways I believe by convenience and choice.

THE CHAIR: Thank you. Sorry.

MR GRIFFIN: Not at all. Can we just continue what we were looking at the top two paragraphs:

"The plan was that my wife and I would drive to the Linden Centre and re-establish communications with Richard, and given the events of the previous evening, possibly with me waiting in my car. Our son would drive to Richard's flat to retrieve details of his private health insurance and then meet up with us and Richard.

Once Richard had agreed a way forward, and a new hospital found, he would have been moved to that location" -- and then you say this -- "Fate intervened and we were to be too late by minutes."

A. Yes.

Q. And we will move on to see what you mean by that in just a moment. Could you take that down, please. Did you and your wife Linda go to the Linden Centre at just before noon on Sunday 17 May?

A. Yes.

Q. When you arrived, were you met by a healthcare assistant at the entrance of the Linden Centre?

A. Yes, but if I could lead you towards that.

Q. Of course.

A. We arrived at the Linden Centre, we turned up and you enter a sort of vestibule type area and there is a controlled door inside that and you can see into an office over to your left. There's an open area behind glass panelling and walling and you can see the patients, you can see what's going on and there's a restaurant over to your right-hand side, a cafeteria area. There was no one in that area at that time.

Q. So you say in your statement:

"Personal ID was not requested", and you weren't asked to sign a visitor's register.

A. No, what happened was we were stood at the entrance trying to gain access and someone walked over, opened the door and that's the healthcare assistant that you mention, and he said to us you must be Mr and Mrs Wade. We hadn't introduced ourselves. We never said yes and we never said no. He simply took it that we were. When I wondered how he had managed to recognise us, he told us it's because we look like Richard. I think if you look at the photograph, he looks no more like us than any other human being would.

Q. We will come on to the photo at the end.

A. Okay, so having done that part there and spoken to him, he admitted us, he did not ask us to put anything into a signing in book, and already I am beginning to think that if these people know that Richard thinks that I wanted to kill him, why on earth are they letting me in through the door and not challenging me on identity or location? So I'm already becoming very suspicious of what's going on because that is the first point of contact and that establishes control for the patient. It wasn't taken.

Q. You say that you were invited on to Finchingfield Ward, that would be you and Linda?

A. That's correct.

Q. You were left there unattended while he went to look for Richard.

A. Yes, we entered the ward, he invited us down to the ward, at this point I am becoming seriously concerned because he was marching us down to meet Richard close to his room. Which means that if Richard was in his room, the first sight he will see of me is standing outside in the corridor, bearing in mind that he still thinks that I want to kill him. So that made no sense whatsoever. But it was also some of the things he started to say as we were walking down. He said, for example, that Richard had had a goodnight's sleep. Well, that's patent nonsense. Richard hadn't slept for weeks and unless they gave something pretty robust he wouldn't have done either. So that I didn't believe. He told me that the doctor was going to come in and that they would be looking to give, to release Richard, which also seemed ridiculous, bearing in mind it was only 12 hours before he had been admitted for suicide. So the things he was saying just did not match the situation and seemed wholly inappropriate for the conversation that you should be having with the parents on first meeting, irrespective of whether the patient thinks that one of those parents wants to kill him.

Q. Another point you raise in your statement, over and above what you have just told us, is that you were left at liberty to walk off and enter other patients' rooms for

example.

A. We could have done anything we wanted to.

Q. And that your second son was able to enter a little later on, again without challenge.

A. Okay, yes. If I can fill some of the time in between those things, but stop me if that's something you want to ask.

Q. We may come on to it. If we don't I will pause and you can fill in then, if that's okay?

A. Okay, fine.

Q. Did your experiences of visitor security at the Linden Centre and Finchingfield Ward inform wider concerns over patient safety and, for example, the risk that patients might be able to leave the ward?

A. Yes. We entered without giving identification. After the events of Richard being found, which I think --

Q. We will come to that.

A. Okay, fine. Then when he was found we moved back to a family room in the reception area.

Q. We will come back to that.

A. In that family room there's big glass panels all the way round so that you can see out and it doesn't feel such an enclosed space, well, fine. But it meant that we could look across and we could see the door opposite.

Q. Can we come on to this because I want to take this in

stages to ensure that we capture everything.

A. No, we were left unsupervised for long periods of time on two wards, the one on which Richard was and on the entrance to another ward.

Q. Let's trace exactly where you and Linda were at different times. The first thing I want to ask is this, though; when you arrived on Finchingfield Ward, did staff know where Richard was?

A. No.

Q. I am now going to move on to the troubling evidence about what happened to Richard, so I just want to prepare you for that.

A. Okay.

Q. I want to ask you about what happened next by reference to what you said in your statement. You cover this from paragraph 56. After you arrived on the ward, where were you and Linda placed?

A. We were placed on the corridor in the Finchingfield Ward looking down towards Richard's bedroom with a clear sight of the bathroom at the far end.

Q. Can I ask you this because we've been hearing some evidence last week about in-patient rooms that have en suite bathrooms.

A. Yes.

Q. If I have understand correctly, is this actually a

bathroom that is separate from the bedroom?

A. Yes, it is. As we looked down the corridor there were rooms down either side, I think Richard was the second from the end, on the right-hand side as we look, and the bathroom was dead ahead.

Q. So you had a good line of sight both of the entrance of his room and in fact of the bathroom.

A. Perfect line of sight.

Q. Thank you. You describe how the healthcare assistant who had greeted you and Linda went to Richard's room on the right-hand side as you have described.

A. Yes.

Q. Learnt that Richard wasn't there, said he would look in the garden and you describe how he was also asking other members of staff if they had seen where Richard was; is that correct?

A. Yes. Having walked down on the corridor and left us in the corridor looking down, he walked down to Richard's room, come out, came back to us and said that he's not in his room he might be in the garden, but then again he might be anywhere else, how would he know he's in the garden as opposed to any other location was the oddity in my mind. He went out disappeared round the garden, came back sometime later, wasn't there, then walked up and down the corridor asking people if they had seen Richard.

I believe another member of staff got involved but it's very difficult to tell because the staff didn't wear any form of uniform or identification. So during the whole of that afternoon, or the hour -- it seemed like a long time -- but for the whole of the roughly the hour and a bit that we were there, it was impossible to tell who were patients and who were staff.

Q. But did there come a time when you heard a shout?

A. Yes.

Q. You heard someone speak.

A. We did, yes. That was after the healthcare assistant had come back and it seemed that two healthcare assistants, again, it's difficult to tell, were coming back asking "Have you seen Richard?", "Is he there?" It was a bizarre show. It didn't look real, it looked staged, it looked wrong. And as they are coming up the corridor there was a shout from somewhere else and I can't tell where, that came from elsewhere, and it said, "He's in the bathroom."

Q. In fact, in your statement you say, "He's in the shower", do you actually recall which it was?

A. I think it would be the shower. Because he would have asked for a shower, he very rarely bathed, he showered frequently.

Q. What could you yourself see at this time?

A. At this time we are starting to see people move around. Immediately after that the alarm klaxon went off. People are now running in all directions so we are half following some of what's going on, trying to work out what's happening. At the start of the process the door down the bottom was locked or at least it was shut and no one was in. When we looked back down, a little later on, the door was open and we could see -- we saw the door was open and we could see Richard's legs poking across the room.

Q. And could you tell was he lying on the floor, as far as you could see from his legs, or was it not possible to say?

A. What we could see was the bottom end of his legs if he was suspended, as we believe he was, it is feasible that he could still have been upright at that time but we could not tell.

Q. I understand, so what you could see was the bottom end of his legs?

A. Indeed.

Q. Were you and Linda then taken to the family room that you just started to describe?

A. We then went to the family room after that.

Q. Was that pretty quickly, I think you say in your statement within 30 seconds you were sent back to the

family room near reception?

A. Yes, could I just add something before that as I think it is material to the finding.

Q. Please do.

A. And that is that while we were there we saw two staff nurses, one male, one female running down and I am not sure if they ran down before the door was opened or not, it's a very difficult time to remember. But they were running down and I know because we saw them afterwards and recognised them as they were the two that opened the door on the second of the two groups, and we will come on to that part a bit later.

Q. Yes, definitely. So you are back in the family room. Was it at this time that your second son joined you?

A. It was. He turned up at the door and he couldn't get in because there was no one manning the door.

Q. Now if I have understood the geography correctly, when you are in the family room you can't see Richard's room or the bathroom or anything?

A. No, you are round the corner by that time and there's a sort of a little chicane in the corridor that would have blocked that.

Q. But you do describe at paragraph 60 what you could see from the family room. You describe a squabble between staff and visitors.

A. Yes.
Q. Now was that squabble anything to do, as far as you are aware, with Richard, or was it something completely --
A. CRAIG nothing, nothing to do with Richard.
Q. And you also describe a paramedic with an oxygen bottle unable to re-enter the ward because no staff were able to open the door.
A. Yes, one of the things that really surprised me is that -- from my time in the navy, we practised emergency situations again and again and again and at any time of day someone knew that they had to man a particular location and do a particular set of tasks in relation to that emergency and it started with for exercise, for exercise, for exercise and it happened every single day. What I couldn't understand is, bearing in mind that they are almost certainly going to get an emergency, and in an emergency situation they are going to have to control the door, why no one was posted on it. In fact, I can't find any record anywhere of anyone saying what their specific job was in any form of emergency.
Q. So this issue about inadequate -- let me just make sure I understand. One of the issues that arises is of an inadequate emergency response; is that correct?
A. I think it's closer to absent.
Q. Absent emergency response, thank you.

A. Yes.

Q. Now during the time that this is all happening, to what extent are you and Linda and your second son being kept informed.

A. All right. Completing the part of *(redacted)* getting in, he only managed to get in when he got, when I approached a -- no that was another point. He only managed to get in when someone else wanted to leave, that person left and *(redacted)* just walked in beside them and the member of staff didn't challenge him at all. He didn't present identification and he didn't sign any book.

THE CHAIR: Classic tailgating.

A. Pardon?

THE CHAIR: Classic tailgating.

A. Yes, just walked through and that was it.

MR GRIFFIN: Were you and Linda and your second son then moved to some seats in a corridor?

A. We were but there are some important issues that happened between those two points in time.

Q. Of course.

A. Shall I cover them now?

Q. Yes please.

A. Okay, we were in the family room and we were given a cup of tea, it seems reasonable, and an apple. The apple seems rather odd, but bearing in mind the shock we had

had, we ate the apple for the sugar to try and keep ourselves going. And if they had done with foresight, then well done for the person that did that. We sat there, we asked for some sort of help, we were given no information, we were told at one point that they had caught Richard in time. What we didn't understand in that, and I don't think the person understood when they said it, was they caught him in time, he had had a heart attack so his heart had stopped, they had got his heart going. What they didn't tell us what that it was so long later that the delay had destroyed his brain but I think we will cover, we will come on to that in your question. So we are now wondering what will happen, so we are pressing for a senior nurse to come and visit us. Finally, a nurse turned up, the gentleman sat down and he put his hand over the front of his face in *this* fashion. And having put it over his face he proceeded to mumble and he mumbled and used words in a bizarre Eastern European Italian accent. I couldn't understand a word he said. He wouldn't repeat anything that he said but the only two words we understood were "choke" and "cord", and that's all we understood and that is the extent of the information that we were given on Finchingfield Ward. We were then moved --

Q. To the corridor.

A. Sorry to complete your question now, I didn't want that part missed out, we were then moved from the family room around the corner on the basis that they were clearing the area so that they could move Richard out. What they didn't tell us was the condition Richard was in. Nothing prepared us for that.

Q. But did you learn that he had been taken to A&E?

A. Yes, we did.

Q. Okay, we are going to come on to A&E but before we do, I would like to look at part of your statement, please. Could you put up the statement at page 12. This is HJA007877 at page 12 and expand (iii) at the bottom. Thank you. Now you have touched on this already but I think it is helpful to look at this slightly more detailed version of what you say in your statement:

"Throughout the time that we occupied the family room, and during emergency conditions, the main entrance was not manned."

And as we have heard:

"At one point a paramedic with an oxygen cylinder was unable to enter until I demanded a member of staff that the paramedic be admitted. Throughout the emergency there was an air of panic" --

A. Yes.

Q. - "and this is reflected in the SIIR. It gave the

appearance of the unpreparedness that comes from the lack of exercises and drills necessary to an effective emergency response."

Now is that what you were referring to earlier on?

A. It is. That's what I led into there. This led to the point where at one stage one of the emergency team that had been called in ambulances had been let out, taken, gone and got an oxygen bottle and was standing with the oxygen bottle outside the door trying to get in and the only way that that person got in was because I walked across to the dining room where there was a member of staff, at least I hope it was, there was a member of staff standing there and I made it plain to them that they need to go over to the door and let the person in because my son is in serious condition down the corridor. That's the only way that that even happened.

Q. Can we read the next paragraph, 51. You say:

"The witness statement of the on-call Dr/paramedic states that the paddles of the defibrillator were on the wrong way, meaning that the initial attempts to restart Richard's heart " -- and you mentioned this he was in cardiac arrest -- "served no purpose and some of the most valuable recovery time lost."

A. Yes.

Q. Could you take that down, please. But is this, again, all part of the nature of the emergency response in relation to Richard?

A. Well, yes. If you are using a piece of equipment and you are doing it in a relaxed manner and you can just pick it up and you put it together and you take your time. It's ease to do. You can follow the instructions, it's not difficult. But if you then put that same person under severe pressure, whether it's a real situation or not, so you bring in some form of simulated stress, that person won't be able to do it that easily. But you will only do that when you have built up the muscle memory of having done it repeatedly time and time again and under as close conditions as you can to the stressful ones you find when you have a patient in cardiac arrest before you.

Q. So this comes back to the point about training and/or drilling to make sure that come an emergency you are ready and able to deal with any eventuality.

A. Indeed, whatever training they did, if it was on their policies or whatever, was of no value in a situation like this, and I think I have alluded on a previous answer that the training had no benefit then either.

Q. I am going to just ask -- I am going to read from paragraph 227 of your statement because that's also relevant here, you say:

"After Richard was found we witnessed one member of staff, and one member of staff only who, seemed to know what they were doing."

Was that a ward manager?

A. I think that would be the role that that person had at the time.

Q. You say:

"The remainder of what we saw ranged from poor to appalling."

A. Yes.

Q. "The documentation available to us provides us with no comfort, as it displays no warmth towards Richard at his time of need."

And you say this at paragraph 228:

The disparities in professionalism, competence and compassion between Finchingfield Ward in the Linden Centre and A&E and ICU in Broomfield Hospital, where Richard was nursed until his death, could not have been more stark."

That was your experience?

A. Yes. If I could just add to that, if I pick up on the question that you asked me previously, Chair, about what would I have done, I would have liked to have seen the quality and the professionalism of the ICU staff, in the Linden Centre. If they could match one tenth of what

those people had my son would still be with us today.

Q. You explain in your main statement that Richard was found unconscious with a ligature around his neck in the bathroom on Finchingfield ward?

A. Yes.

Q. Did you subsequently learn that he must have ligatured using pipe work in the bathroom in what you regard as a foreseeably dangerous location?

A. Yes, we did. We were not told that he had ligatured himself completely. All we heard was "cord" and "choke". That's all we knew when we left the Linden Centre itself. So we picked this up in police investigations and other investigations as it goes along. Now, the ligature itself, the first time we were told it was a ligature was in the A&E department over in the hospital, and do you want me to go there?

Q. We will come on to that in a moment.

A. Yes, but it was a ligature that we were subsequently told.

Q. Do you make this point at paragraph 198 of your statement that Richard did hang himself and that that conclusion is important, let's just remember this is mid-May 2015, and that conclusion is important because in February 2015, just three months before Richard, another gentleman took his own life by hanging in the very same room as Richard?

A. Correct. In February of that year a gentleman hanged himself on a separate ligature point in the bathroom. When Richard used it, you have mentioned the pipework, so I will use that term, and it's absolutely obvious that the pipework, you cannot miss it. A few things suggest that Richard hanged himself and didn't just self-ligature. The first of them is that the autopsy report, the pathologist on three separate occasions mentions that the wounds and the marks and lesions on Richard and the type of death and the damage done to him was caused more than likely -- sorry he used the term consistent with hanging rather than self-ligature. He points out that self-ligature is extremely difficult anyway. The next part of the evidence is that on the pipework itself the damage that was done would have been consistent with Richard hanging himself and consistent with nothing else, in the way that it is broken. The point that finally convinced me on this was when I did something the police, and the Trust never did, and that's elicit from an eyewitness that Richard was in fact connected to the pipe, and I know who undid the knot and I know how the pipework had become broken.

Q. So two points. One is that the evidence when you put it altogether indicates that he hanged himself?

A. Yes.

Q. And the other thing is that this was coming not long after another gentleman, as you put it, had also hanged himself in the same bathroom?

A. Well, yes, and after that the CQC which I guess which will also cover --

Q. We will touch on that briefly.

A. Did an investigation. That would have triggered and we had the discussion with the Trust on 5 August that there should have been some repairs made. The pipework itself was still there when we returned to meet with the Trust on 5 August. We were taken down to the room.

Q. We will come on to that in a moment as well.

A. Okay.

Q. I am going to move on now, Robert, to the A&E and the ICU. Before I do, is there anything else you would like to raise before this very difficult piece of evidence?

A. I think you have pulled on the leash on several occasions. We will cover those when we get there.

Q. So A&E at Broomfield Hospital?

A. Yes.

Q. You describe in your main statement from paragraph 64, arriving at A&E and going to the family room there.

A. Mmm hmm.

Q. What happened whilst you were in the family room?

A. Okay, the three of us left the Linden Centre in two cars.

We drove over to the car park, pulled over into the hospital, up to the desk to find out what was going on. They knew that Richard was there. We gave reasonable identification, and they directed us towards the family room, so that we could wait there whilst we were waiting for some news of Richard. In there, there were already two people. There were two ladies, one sat in the corner wearing black and another one sat here, I believe it was a blue dress that she was wearing.

Q. You said a blue dress?

A. I believe it was blue, and she was sat with her hands on her thighs, like someone waiting for an interview, which struck me as an odd way to sit in A&E if you are waiting to find out the condition of a loved one. But that didn't do much. We started talking, and we were really trying to struggle to understand what had happened to Richard, we had been given so little. Clearly, the lady in the corner, dressed in black, clearly recognised that our circumstance was somewhat uncomfortable or we had made her feel uncomfortable, I don't know which it is, but she had the common sense and the politeness to leave the room to us, so that we could deal with the troubles that we had. But the other lady stayed and she didn't say or do anything. She just sat there and we talked and we tried to rationalise what was going on. Then it

dawned on me that she still hasn't moved, she was like a statue, sitting with her hands on her highs. At this point she said that she was from the Linden Centre. If she is from the Linden Centre and she has come over about Richard, we are going to want to know what happened, so we started pressurising her with questions. In that at one point we told her we didn't know how he died. So she demonstrated how she had been told, because we found out that she hadn't been in on the morning. She only turned up in the afternoon after Richard had hanged himself.

Q. Did she inform you that Richard had choked himself using a cord?

A. Yes.

Q. But did she also demonstrate it and did she demonstrate it in significant and graphic detail?

A. Together with facial expressions, yes.

Q. Thank you. What was your reaction to what she said and to the demonstration that she gave?

A. Utter horror.

Q. Did you also speak with an A&E doctor?

A. Yes, we did.

Q. Did he inform you of the seriousness of Richard's condition?

A. Yes, he did. He told us that Richard had severe brain damage and it was most unlikely that there was any chance

of a recovery.

Q. Was Richard transferred to the intensive care unit?

A. He was.

Q. You explain in your main statement and you say this at paragraph 69:

"At ICU the full extent of Richard's injuries were revealed to us. The extent of those injuries were such that they provoked a senior ICU charge nurse to issue a safeguarding report for the first time in his career."

Correct?

A. Correct, yes. He was so upset by what he saw. The -- there was one point I would like to make about the A&E waiting room, but I think we will deal with this and then go back.

Q. Yes.

A. Richard had hanged himself and the ligature had completely closed off the blood to his brain.

Q. May I just say this, Robert. There will be a variety of people watching and listening to this evidence, so whilst it is very important you are able to give a true account, could I ask you to do so with some care just with an awareness of people who may be listening.

A. Of course. Let me express it this way, then. I am a fairly robust person, but when I walked in to see Richard

I couldn't last more than a matter of seconds before I had to walk out.

Q. I am so sorry.

A. That was true of everyone that came, we warned them of the condition that he was in. The state that he was in was nothing representative of the person that went into care the day before, and it was that state that provoked the charge nurse to write the document. His work colleagues who turned up, and we advised them of Richard's condition and they were running out crying at what they saw. It was truly a horrible thing to happen to him.

Q. I am very sorry the hear that. Robert, you said there was another matter that you wanted to refer to while you were in the family room?

A. Yes, there was. Bits of this may come up elsewhere, but this is a link I think that is important and it sets the scene of maybe the mindset of the Trust that day. The healthcare assistant wrote three statements.

Q. Is this the healthcare assistant from the Linden Centre?

A. In the A&E.

Q. In the A&E, thank you.

A. She wrote three statements. The first of which was in May, so this is dated on the day of he incident itself and her going on to the A&E. Now, she came over to the

A&E and the Trust supposedly sent her over for our care. Now, I challenged the Trust on this, and after challenging many times and discounting their arguments all the way through, if she was sent over to care for us, I would have thought she would announce herself to us, but this is from the associate director of quality, it's on the list over there, and that particular person accepted, "I know the member of staff didn't identify who she was and this again is something that we'd have expected to occur." From that they wouldn't meet with us or allow us to meet her or get anything else from her. On her three statements that supposedly she is there for. The first statement, all about us for the most part, runs on to three pages. If you look at the evidence of what's written down of what Richard said in the hospital, it amounts a two half lines. Now, in mental health it would seem to me that the only thing that you've got, you haven't got stethoscopes, you haven't got blood pressure metres, none of these apart from their physical health are relevant necessarily to their mental health. The main way you can see what happens to the patients is, one, by how they act and, two, by what they say. Those records are absolutely critical to developing the picture of the patient. In twelve hours two and a half lines. In a matter of minutes three pages.

Q. You think their focus was not in the right area?
A. I will say exactly where their focus was and, if I may, I just need to get the right person on here. There is when the lady was returned back over to the Linden Centre, this information was fed back to the team including the operations director. What difference to Richard's health did knowing about us make to the Linden Centre? He was already beyond help and destined to die just four days later, so why start finding out about us for someone who was supposedly there for our care and didn't even tell us?
Q. Thank you. I want to look at a brief chronology, please, to take stock.
A. Okay.
Q. The Suffolk Mental Health Crises Team attended outside your home on the evening of Saturday 16 May 2015.
A. Yes.
Q. Richard was admitted to Finchingfield Ward at the Linden Centre in the very early hours of Sunday 17th May?
A. Yes.
Q. He was taken to A&E, was that later on the Sunday?
A. That was about somewhere coming up to 1 o'clock, I think he moved over to the A&E, so it was twelve hours to the point of the incident and then we left at just round about the 1 o'clock time, and he had already gone by that

time, just before. So the whole of all of these incidents had taken place in a compressed period of time, yes.

Q. He was transferred to ICU?

A. Yes, he was.

Q. And tragically Richard died on 21 May. Which was a Thursday I believe.

A. Yes, he did.

Q. So this is all happening within a condensed period of time in terms of his time on the ward, but also just over a matter of a few days?

A. Yes.

Q. I am going to move on now, Richard, to the meeting of 5 August. Before I do is there anything you would like to raise at this time?

A. No, I think the points have come out on that part there.

Q. So moving now to 5 August 2015, you attended a meeting with NEPT; is that correct?

A. That's correct.

Q. You refer to this meeting in your statement from paragraph 113. What was the purpose of the meeting from your perspective?

A. We had a whole bunch of questions that were unanswered, very much the area that the Inquiry is around at the moment.

Q. Who attended from the family?

A. I beg your pardon?

Q. Who attended from the family?

A. My wife and I.

Q. You describe at paragraph 116 that the following attended from the Trust: "The deputy director of nursing" --

A. Yes.

Q. -- "the operation director at the Linden Centre, and the charge nurse who had also been present on 17 May."

A. Yes.

Q. Where did this meeting take place?

A. In the Linden Centre.

Q. Can I ask you a question about that. Were you surprised about the location for the meeting, namely the place where Richard had been able to ligature, or did that seem appropriate to you?

A. I would say by this stage I was beyond surprise. I don't think there was -- I reached a point in dealing with the Trust where worrying about things, such as tact, really didn't matter any more and I was more concerned with fact than place.

Q. During that meeting, were you escorted to the bathroom where Richard had ligatured?

A. We were.

Q. You say this at paragraph 117:

"When the charge nurse escorted us to the bathroom we passed though a locked door" --

A. Yes.

Q. -- "On the other side of the door a patient was sat on the floor" --

A. Yes.

Q. -- "To our amazement the charge nurse stepped over her and then when we entered the bathroom we were shocked to see the pipework repaired but not enclosed."

And I think you touched on that earlier?

A. Yes.

Q. What did you think, putting the charge nurse stepping over a patient to one side, what did you think about the fact that the pipework had been repaired but remained unenclosed?

A. Madness, I cannot think why you would want to do that. Following the death in February, they changed the ligature point then, but on this occasion there's a ligature point and you look at it you can't miss it. It's there. It's one of the first things you see when you open the door and it was there and it was repaired.

Q. And this is in the context, as you tell us, of a gentleman who had in February died in the same bathroom?

A. In the, by the same method, yes.

Q. You say in your statement, this is paragraph 115, that

during the meeting with the Trust, you found out that the Trust did not have a separate ligature policy.

A. No.

Q. That patients were left with belts and cords, i.e.. ligatures, for their dignity.

A. Yes.

Q. Despite this being contrary to their search policy.

A. Yes, that policy struck me particularly. The argument was that one of the important things for patients was their dignity. I asked the question, to which again I didn't get an answer, and that is what is the dignity of dying on a toilet floor? So I think that just puts in stark contrast. But on that point of ligatures, while I was talking to the deputy director of nursing there, she was wholly obsessed with the concept of ligature points, which seems bizarre bearing in mind they repaired one, but she was wholly concerned with those. If the ligature points were so it wouldn't happen, despite the fact that the Trust is trying to make the case that my son self-ligatured and didn't use a ligature point. She looked absolutely bamboozled, when I pointed out that the only common thing in a strangulation, be it a hanging or self-ligature, is the ligature, not the ligature point. It was like no one had ever explained that to her before, her mind was so linear in her thinking. I don't think

she was an uncaring woman and I don't think she was unintelligent. In fact, I think she was very bright and I thought she spoke with sincerity when she tried to comfort us and I don't think otherwise, but like the rest of the Trust, this linearity of thinking, it's a laser beam straight ahead, nothing to the periphery.

Q. You add amongst the things that you learned during this meeting was that the Trust representatives did not know if by policy the bathroom door, behind which Richard happened himself, was supposed to be kept locked or left open.

A. No, they didn't know. Can I just go back a bit, the lady behind the door, and the door is important, because that door was locked the day we went there on 5 August. But on 17 May the door was open because we never went through a locked door on that occasion. The poor lady on the other side, she was in a terrible mess, the poor lady, it really was sad to see. She was trying to roll a cigarette with her hands. She was having difficulty doing it, to get the bits together to have a smoke. It was just sad to see. It shouldn't happen. There should be more dignity for people?

Q. The 72-hour report addresses bathroom doors and you say this in your statement, paragraph 123, that one of the two recommendations was that in-patient bathroom doors be

kept locked until required for use?

A. Mm hmm. Yes, if there's reasonable separation between toilets and bathrooms and the toilets are properly constructed such that they are safe, or everyone the novel idea of someone on level 2, if they have got suicide in their record, have someone with them whilst they are separated out. But no, it's, they are managing it all wrong there.

Q. You have touched on this, about the bathroom door being open twice during the incident?

A. Yes.

Q. Can I come to that now please?

A. Yes.

Q. You have concluded that staff opened the bathroom door on Finchingfield Ward twice on 17 May.

A. Yes.

Q. This is paragraph 175 of your statement onwards, you refer to two different scenarios, each with two members of staff arriving to find the bathroom door locked. One member of each group unlocks the door, the door is opened and Richard is found on the floor. And you note that:

"The SIIR could not answer the question of which of the two groups of staff opened the door and that the possibility that the door was in fact opened twice was expressly raised and acknowledged at Richard's

inquest."

A. Yes.

Q. And your own conclusion, as I have just mentioned, is that the door was opened twice, once by each group of staff.

A. Yes.

Q. This is what you say at paragraph 186. If true, this means that Richard was found, then left alone with a ligature round his neck and the door locked on him. Now, have I correctly summarised that particular point?

A. Yes, you have. When we were met going into the hospital, I told you that the behaviour of the person was bizarre, he was saying things that you wouldn't say in that circumstance. So for some reason he was off a normal script. It didn't make sense why at the time, but he was not speaking as someone should speak to you. Then, when we went over to the hospital at a later point and everything had gone through, my son and I talked that through and the only thing that seemed to make any sense, of all the scenarios that could be, was that he must have known Richard's condition to have behaved in such a bizarre manner and said such odd things that patently weren't true. So we put it as a strong possibility that the door was opened twice. Now, I can't imagine in any way, shape or form that you could confuse yourself

whether you unlock and open a door and find someone hanging themselves on the other side of there. I don't know how you can make that mistake. My personal experience of life is of all of the things I have been involved in that really impress on your mind, I can see them quite clearly and I could call some of them up now as I speak. They are there, they don't go away. Yet somehow this completely false memory of opening the door and finding someone hanging behind it, has arisen in their head. But then you would have to do it to one or other of the groups. What about if neither of them have got that wrong. What if they both have that right? They did open the door? If you look at the evidence and the descriptions that they give, when I finally got hold of the statements and I was able to examine them, it only reconfirmed that for me. Early in the process we got involved with, I think it's Channel 5 News, but we got involved with a news company as we tried to get some traction to having our story listened to and heard. Two young ladies turned up and the two of them were as sharp as razors, they really were as bright as buttons. I gave them the evidence, stepped back and left them to have a read. After a relatively short period of time, in relation to the evidence they needed to read, they had a short conversation, one looked at me and said, "You do

realise the door was opened twice", without me telling them. The answer is I believe -- there's even a YouTube video of that still on the internet.

Then at the inquest, as the evidence was being given, one of the members of the jury, most likely the Chairman speaking on behalf of the others, asked a question, "Does that mean that the door was opened twice?" And the coroner said, "That's where the evidence seems to point." That seemed to be sufficient and the whole thing just cruised on past. Now, if it was opened twice, that means that Richard was found hanging and not only found hanging, but left hanging because I know the second group were the ones that undid the ligature and removed it from the ligature point.

Q. Thank you. I am going to move on to a new area, Robert. Before I do is there anything else you would like to say about what we have covered so far?

A. There are a couple of points I think I would like to raise. That is the Trust, everything was delayed in terms of the generation of the reports and when they were written. The report, the 72-hour report should have been written in 72 hours. We have already covered on that. The report itself comes up, and it seems to suggest that it was written within the 72 hours but then never made any distribution. What I cannot understand is this.

That if they had written the report in May, by the 20th, as it is written here, why, when we met in August did the gentleman sat to my left, who was the operations manager, not mention it? I would have thought he would have done because one of the people that was signatory to it, as I understand it, worked in that department so he would have known about this report.

Q. And you have explained already that the first you heard of the 72-hour report was some significant time later?

A. It was, it came much, much later, but the gentleman I was speaking to, who was the assistant quality director, I think I used the term earlier, I can't understand why he hadn't seen it until the September. So all of that I find very troubling around the report itself.

There was one other point I wanted to make.

Q. We may pick it up because we are gong to move now to address investigations and, as I have said, at the end I will pause just to let you regroup.

A. Sorry, I do have the point if I may. If you read the report, it's very scant. If you read the instructions on the back page, they are quite specific. Nothing was done according to the requirement. That was the point I wanted to make.

Q. You describe in your statement the long road to this Inquiry, basically.

A. Yes.

Q. And the various investigations that have taken place along the way. We have just discussed the investigation that led to the 72 hour report and matters surrounding that. There was also, as we have heard, a serious investigation report. You have fundamental concerns about the SIIR, which you detail in your statement and you say this, this is paragraph 126:

"I have profound concerns regarding almost all of the contents of the Trust's SIIR of December 2015 as demonstrated in my response in January 2016."

And you, amongst the concerns that you raise in your statement are that its independence was compromised by the fact that it was conducted by a nurse at the same Trust.

A. Indeed. On that one, the report itself was written by -- I will try and get the right name for you here, sorry the right title.

Q. We can refer to this person as the author of the SIIR.

A. Okay, the author of the SIIR was -- in a conversation that we first had with the Trust or had been involved in it, was presented to us, and without saying as much, very much that he is independent of the Linden Centre, well he was independent of the Linden Centre in so far as he worked in the western area of the Trust. Now, given his

job title, it's most likely that he either reported directly to the director of nursing who sat on the board or through no more than one other to have a title such as his. But what really troubles me about that is not just that he did it, but it was in contravention, as I would understand it, to the Serious Incident Framework published by NHS England which controlled those matters at the time. In that framework, sorry, in that framework, towards the back here it clearly states:

"An independent investigation should be considered for the following circumstances that is independent wholly of the Trust: A serious incident where the organisation is unable to conduct an effective, objective, timely and proportionate investigation. This is particularly relevant incidents where the obligation of the authorities to account for the treatment of the individual is particularly stringent, including" --

Well, I think we come nicely under that:

-- "Deaths (and near deaths resulting in severe harm)" --

So we have qualified for that one:

-- "of those detained under the Mental Health Act ... and, in certain circumstances, the deaths of informal psychiatric in-patients."

So these are the conditions that now cover the

admission basis of Richard:

"The cause of death is unknown" --

Well, it was known; it just wasn't correctly communicated:

"Where there is reason to believe the death may have been avoidable" --

Well, we do know it is avoidable because in the very first letter we see from the CEO of the Trust he stated that he was saddened because Richard's death was avoidable, so we clearly qualify for that:

"Or unexpected, i.e. not caused by the natural cause of the patient's illness and underlying medical conditions when this is managed in line with best practice."

Q. So is the short point that the policy is clear that the conducting of an SIIR by someone from the same trust is clearly in breach of it?

A. Yes.

Q. You go on, and we will look at this later, but you go on to make a recommendation specifically addressing this point, don't you?

A. Yes, I do, but no trust should ever be allowed to do an investigation of this nature into itself. They are marking their own homework and we all know where that leads in the end.

THE CHAIR: Just to be absolutely clear because I know that on occasions organisations will do one themselves, in order to get it done quickly, and will then employ somebody independent to do an investigation, and so far as you are aware, no independent investigation was undertaken?

A. It was presented to us as if there was some sort of separate independent investigation, in that someone would then be looking through all of the documents to go through it, but that turned out to be an editing service, as I understand it.

THE CHAIR: Okay. Thank you.

MR GRIFFIN: Moving on, you refer in your main statement to two CQC investigations; one that had been launched in February 2015 into the death that we have already discussed, and another into Richard's death. And you have raised concerns that the CQC into Richard's death -- concerning that, was it that one of the investigations was quite focused on the death and was it in Richard's case it was a much wider investigation; was that one of the concerns?

A. Yes, I would express it slightly differently, if I may. The CQC doesn't do investigations into deaths, that's the responsibility of other bodies, but what they can do is look into whatever detail they like in the way that a

particular hospital or trust is managed. Now on the first of the investigations, that's the one that followed from the death in February, they did a relatively detailed look into the Trust and into the area where the gentleman died, and having done that that they came up with a report with some fairly strong recommendations. In Richard's case, bearing in mind that we are now back in the same room, with the same cause of death, with a ligature point that should have been repaired at the time of the other one, and when I asked for a list of the repairs that should have been done I was told that the list had been lost, like many other documents. In that situation, what the CQC did was they looked broadly across the Trust when they had a clear problem right under their nose, and that I don't understand.

Q. There was another element in that communications between the CQC team and yourself were poor, as you describe it, that led to a complaint and in summary, Robert, whilst you were unhappy with the CQC investigation, you were more happy with the way your compliant was addressed; is that correct?

A. Yes, I was, if I could just pad that out?

Q. If you could do it briefly because we have got a little more ground that we need to cover, so please do but.

A. Okay, I will put this one very briefly. The report that

the CQC came up with was a very powerful document and it is the only document that I've seen so far where a public institution has had the courage to be honest about its own failings and how it is going to deal with them. In that sense, I think it is a very good report. What they have written doesn't make good reading but for my story of how I got here, it was a seminal part in gaining access and ending up here today. So it had a benefit.

Q. Can we be clear that the report that you are talking about, this is the report following your complaint.

A. Yes.

Q. It's not a report addressing matters of the Trust. This is addressing failures in relation to the way the CQC have conducted the investigation.

A. Yes, that's correct.

Q. Thank you very much. And as you say, the honest approach in that report was of significance to you.

A. Yes, to put it really simply and that is, if I had had the same degree of honesty and integrity in the other reports that had been written before that, from my point of view much of this wouldn't have happened this way, it would have taken a very different course.

Q. You tell us also about Richard's inquest which took place after some delay. Did you privately fund a barrister for the inquest?

A. Yes, I did.

Q. You make two observations about the inquest process, I want to make sure I have understood them. This is paragraph 214. In essence were you concerned that there was a large bundle of documents put together for the inquest, but insufficient time allocated actually to deal with all of them?

A. Yes. If you take a full ring binder they fill four of them. Reading that amount of documentation and understanding it is impossible. The barrister, we employed two barristers, one in sequence and I will be blunt about what the first one did. She waited until it was almost too late and then she gazumped us by putting the prices up at the very last moment. We employed another barrister and I will take my hat off to the gentleman. He got full control of the facts of the matter in the limited time that he had but he didn't manage to get to the point of the linkages between them. He didn't have sufficient time for that, so he and I had to work at that during the inquest itself.

Q. You had previously, I think, maybe in September, you explained the toll that this long path to this Inquiry has taken on you. Is this an aspect of that, having to brief a barrister very much at the last minute in relation to matters that must have been of great concern

and worry?

A. Mm hmm.

Q. Thank you. Do you also note in your statement that there are many deaths in the scope of this Inquiry that will have passed the desk of the Essex Coroner, and do you say in your statement it's difficult to understand how this pattern was not noticed and if noticed, not acted upon?

A. Well, yes, there's one central Coroner's Office in Essex and it's in Chelmsford. This Inquiry started out with the Chair mentioning the 2,000 deaths that formed the basis of the start of the investigation that's here. Many of those deaths must have passed across because they weren't natural deaths, so they must have passed across the desk of the Coroner. That's their job to monitor those. If that happened over 20 years at 2,000 deaths, that's 2 deaths a per week, I don't know how you can't notice a pattern. They have then issued on many of those, preventions of future deaths that have done absolutely nothing to change anything and yet the process carries on and I don't understand why.

Q. Thank you. We have touched on one of two police investigations, can we just deal with those briefly. First of all, there was a corporate manslaughter investigation conducted in 2015 by Essex Police. Is it right that you enjoyed a good relationship with the

detective inspector who is running that investigation?
A. Excellent relationship. He was a very slow methodical man, worked his way through the facts. What I did notice was that as his investigation went on and started to get closer to the truth, then he seemed to have fewer and fewer resources at his disposal, and towards the end it seemed to be a side project that he was doing. He managed to get to the point to pass charging advice to the CQC, which I thought was a sterling effort and we were able to debate points quite strongly and see where the merit of the arguments were and those I won went into the evidence and those that I lost didn't, and I think that's good and I think that's how it should be.
Q. Am I right in thinking that this investigation didn't lead to any criminal charges or proceedings?
A. No, it didn't. What happened there was the CQC didn't approve the charges. On the first one, if I remember correctly, it was on the basis that they believed that the seminal part of the evidence for them was that the search wasn't done, I think they called it professionally, was done properly, which seemed strange given that the Trust had settled out of court on that very same point. So I couldn't understand. So I complained and I wrote an analysis of where I thought their faults were. They didn't send me the analysis,

their response to that until just before Richard's inquest, and then after the inquest the police announced that they were going to do a second manslaughter but on a much broader basis than the one they had done before.

Q. So this is 2017 by Kent and Essex Police?

A. That's right.

Q. I think you mentioned earlier that it was a detective chief inspector who was leading on that.

A. That's right, yes.

Q. Were the crimes to be addressed corporate manslaughter, gross negligence manslaughter and all other incidental crimes as you describe them?

A. That's what he said to us at a meeting at the, I think it was the sports club or some sort of a club area at the central Essex Police Station.

Q. Were families told that the investigation would leave no stone unturned?

A. Yes, it was.

Q. What was the working relationship like with the family during the second investigation?

A. There was wasn't on of any meaning.

Q. You describe it in your second statement as there being no meaningful communication.

A. That's correct. The only communication that we had was that we had one interview of about an hour, but that

wasn't into corporate manslaughter, that was into any other criminal charges that we thought might be relevant. We gave the police documentation to support those other charges. Early in the following year my wife received an e-mail just saying that they were no longer going to pursue any other charges. At no point was I ever interviewed about or gave them evidence of corporate manslaughter.

Q. Thank you. You have already mentioned that you brought a civil action against NEPT which was settled.

A. Yes.

Q. You also refer in your main statement to working with your local MP, James Cartlidge, at the time.

A. That is correct.

Q. You say that his support has been, as you say, "invaluable".

A. Correct.

Q. Did he secure a debate in the House of Commons about Richard's case?

A. Yes, he did.

Q. Did that in turn secure an independent Inquiry into Richard's death?

A. It did.

Q. Does that bring us then to the Essex Mental Health Independent Inquiry?

A. One more step.

Q. Yes, tell me.

A. And that is having had the independent Inquiry offered -- sorry, offered to us, it was then broadened out to other people. The families had to choose their route from there. My view at that point was, given all of the impediments that the state, for want of a broader term, had put in front of us, that if we didn't co-operate with that then what we would end up is continually being told, "But you were offered." But having decided not to go down that route I pressurised the minister, or spoke to the minister more accurately, and received from her a statement that effectively said that the reasons why there couldn't be a public inquiry into Richard's death was because one, public inquiries are normally about groups, that's not totally true they can be done on individuals, and secondly, there was no evidence of systemic failure.

Q. What was the name of the minister, do you recall?

A. Sorry?

Q. What was the name of the minister?

A. That was Nadine Dorries.

Q. Nadine Dorries, thank you. That does bring us a grouping of different cases to be considered by the Essex Mental Health.

A. And it was the failure of the Essex Mental Health on those two grounds that left the minister nowhere else to go but to capitulate to all of the other pressures that had been placed upon him.

Q. And that led us to here and to today and you sitting giving evidence to the Chair?

A. Yes.

Q. Robert, I am going to move on to cover your recommendations next. Before I do is there anything further you would like to say about the route to your evidence today and to the Lampard Inquiry?

A. No, I think I have recalled back all of the things I wanted to raise on the way through, thank you.

Q. Could you put up please the recommendations, please, HJA009990. I think we have covered the first one but may I read it out anyway:

"The Trust must never again manage a serious incident investigation into either a death or near miss occurring within itself; instead being managed by a different trust with independent legal oversight nominated by, and reporting to, the victim's next of kin."

Now I think we have covered that but is there anything else you would like to say about that now?

A. Yes, I think it is a matter of not allowing that to grow

too far and therefore swamping the system. I think we got very close to this on a point, on a question you asked me earlier, Chair. That is that this needs stick at the very top of the triangle because as you come away from the top of the serious incidents, a number of lesser incidents will grow massively on the way down. The idea is not to clog the system up but to remove the ability of a trust to write an SIIR that then forms, as it has done, T the centre piece of what happened at the Inquiry -- sorry, at the inquest, what happened at the first police and the second police investigation and forms part of what the CQC would look at. So they should not be managing that document. And then to make sure that it's managed, the oversight that's given to the whole thing should be a route back to the family so that they can press the alarm bell and when things are going off and intercept things that are being done that are incorrect.

Q. Thank you, that is very clear. Can we see two further recommendations:

"The Trust redesign its entire care delivery service by using safety cases within a patient safety doctrine (as outlined in the attached proposal) and the CQC and Coroner develop mechanisms to track and report a range of performance data relating to the patient safety doctrine for mental health care."

Now I think both of those take us to the doctrine, and unless there is anything you would like to say at this stage, what I propose to do is now to move on to discuss your doctrine.

A. Okay.

Q. Could you take that down, please. Could you put up the doctrine, this is HJA010168, and could you expand up to and including the first paragraph of the introduction. Thank you very much. Do we see here the title, "Proposal for a National Health Service (Mental Health) Patient Safety Doctrine." Now this proposal was written by you with the assistance of ChatGPT?

A. Yes.

Q. Does it say this that it aims to provoke:

"A structured discussion on the formulation, validation and rollout of a patient safety doctrine for mental health patients in the United Kingdom. The Lampard Inquiry is considering a significant number of deaths over an extended time period. This proposal hypothesises that the relevant mental health model care has systemically failed and is incapable of self correction and should be replaced by rapid evolution into a radical solution."

Just to make sure I have understood, please, is the starting point of your doctrine, therefore, that the

current approach is not working and cannot be made to work?

A. Yes. If I may expand on that?

Q. Please do.

A. I have already covered the number of deaths and I have already covered the fact that they passed through the Coroner and they have led to a whole number of prevention of future deaths, none of which has changed anything.

At the beginning of our investigations into all of the things that have happened the senior medical doctor within the Trust stated, and I think it was in one of the minutes of the Trust board itself, that he could find no pattern within the deaths that happened. My second son said, "That's because there is no pattern, it's random." What they are managing is so thin that deaths could take place anywhere and you can't see them. But I believe it is possible to see and why these things happen. I have missed out some of the things, it would have gone a little bit too far on detail, but i will cover them now and how I arrived at going into this. If you look -- my wife loves a good murder mystery, and in a good murder mystery it always boils down to the clever interpretation of means, motive and opportunity. Let's have a look at those three in the case of Richard. In the case of Richard, the motive was suicidal ideation.

The means was the dressing gown cord that he used, that he was left with. And the opportunity was being left in the bathroom which broke the protection of the level 2 rounds. If you want to stop anyone taking their own life, then you have to remove, and make sure those, a combination of those or certainly two of them never happen. You don't let them go together. And what can you use to prevent them coming together? Well you need some form of safety process that goes round it. The National Rifle Association has one -- this is other stuff I have been reading in the background to this -- has one that is their safety practice, and it's safe people, using safe equipment with safe processes in safe places. I can't think of anything that doesn't fit better here than patients, or people which are the patients and the caring staff, the property, which is what the patients have, in this case the ligatures, the scissors and all the other items and then what the staff have that you need to deny them access to. A complete rethink on the policies and the way that you can read them and understand them, and the places that they're in being made as safe as possible, safe as possible or if there are things you can't do you manage these other factors, such that those three items; the means, motive and opportunity never come together. So this is by no means

meant to be a full and complete document. It is just that it is a way to start the discussion, to come up with a better way of doing things, because if you map out the 2,000 deaths in any space, you will always find that it's lights coming on in two or three locations of how people died, never one, and that's why that chief doctor couldn't find any pattern within them.

MR GRIFFIN: Can we just look at the rest of the introduction there because that picks up on what you have said a little bit, and provides a little bit more information about the background to this document:

"This proposal adapts the structured processes of military doctrine development into the area of National Mental Health Policy."

Now, you mentioned earlier in your evidence that you were in the Navy; is that right?

A. That's correct.

Q. Are you therefore drawing in part on your own experience, past experience, in the military?

A. In part on that, in part from management positions I have held and the rest of my life and the things I read, yes.

Q. And in fact, elsewhere in this document you, I refer to other areas you have drawn, for example, the nuclear industry and the aviation industry.

A. Yes.

Q. So industries or areas that have to do with high risk situations?

A. Hm mmm.

Q. "While the military doctrine often incorporates obfuscation and deception at strategic operational and tactical level, this report deliberately excludes such elements, instead it emphasises transparency, ethics, trust and evidence based practice as their guiding principles. A structured methodology that includes clear and well-established principles, testing with validation, dissemination of information and is accepting of controlled revision at all levels is employed to provide a rigorous framework for mental health system reform."

Thank you, could you take that down, please. Now, the doctrine covers various further points. You referred before to the safety case, using safety cases, and in fact does the report address in further details the safety case approach and does it give a couple of worked examples of how it might work --

A. Yes.

Q. -- including, if I have picked up on this rightly, do you draw on Richard's experience? For example, one of the safety cases relates to ward observation.

A. Yes.

Q. Thank you.

A. I try to stick as closely to what I had a reasonable and valid opinion on as I could.

Q. Thank you. And you come on, you provide the conclusion, you provide two annexes, including a generic safety case structure. Robert, I can assure you that the Chair and the Inquiry will be considering that in some detail and with great care. Is there anything else at this stage that you would like to draw our attention to arising from the doctrine?

A. Yes, so I think it's linked end to end and I will start at the patient end of it with the safety cases. The safety cases are developing process and procedure that is deeply embedded into many high risk industries including the National Health, where, since our second son first introduced that as part of an afternoon with the Essex Mental Health Inquiry and hopefully that material was available to you, because he is far more of an expert on that than I am.

Q. Yes.

A. Now if you look at the idea that happens there is you never take, instead of having a thick monumental document over here that you can't find what you want, as you come to do a particular piece of work on a ward, on a mental health ward, so you effectively have a job card if you like. On that it tells you the aim of what you have got

to do. The objectives you are going to do and how you are going to prove that you have made it safe for the patient.

Q. So this is a practical approach.

A. This is the practical approach. Now, by doing it that way you can put on to those elements of work all of the things across all of those different documents in one place relevant at one time. They can now have their mind clear on what they are trying to achieve. When you have achieved that you can now link all of those safety cases to make up a whole overall procedure of care for a particular patient. You can also manage your staff more effectively because within them you can state who is qualified to do it, what level of qualification they need and you can map that to the individuals of whom you have proved can actually do those safety cases and do they need supervision, oversight or can they do it on their own?

So you can build training programmes, have staff come in, they can used to using the safety cases and the nurses now know that someone that they haven't met before has actually been approved to do a whole series of work, and the nurses, instead of worrying about every singling detail, can use their professional skills to put all of that work together into a comprehensive

pattern of care for the patients themselves.

Q. If I have understood correctly the purpose of this document is effectively to start a discussion?

A. Yes.

Q. The starting point being that there needs to be fundamental change?

A. The word "proposal" at the beginning gets your attention. The fact I used the word "hypothesis" below it, probably is a bit more honest.

MR GRIFFIN: Thank you. I am going to move on now. We have come to the end of the questions I have for you. The situation is this, Robert. In a moment we will put up a photo of Richard and your family. Before I do that, I want to make sure that we have covered all of the key points that you feel should be covered in your evidence today.

A. I think so. It is difficult to think of anything else.

MR GRIFFIN: This is the process, we will put up the photograph, I have seen it, it is a lovely photograph of the family. That may well be the end of your evidence, but we will just break to check whether there are further questions that need to be asked. If there are no questions then you don't need to come back.

A. I was informed of one question.

Q. We have covered that. Could we then put up the

photograph, please, Amanda.

This was clearly at one of his graduations.

A. That was his Ph.D.

MR GRIFFIN: And that looks like a very happy occasion.

A. It was, it was a lovely day.

MR GRIFFIN: Thank you very much. Chair, do you have any questions?

THE CHAIR: I have no questions. I just want to thank you very much indeed. We have worked you very hard, this afternoon, but I am very grateful for it, thank you, and to your wife too.

(Break)

HEARING MANAGER: There are no further questions for the witness, so that brings us to the end of today's proceedings. We will reconvene tomorrow morning at 10 am.

(5.03 pm)

(Adjourned until 10 o'clock on 21 October)

I N D E X