THE LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF TAMMY SMITH

I, Tammy Smith, of an address which is available to the Chair of the Lampard Public Inquiry, **WILL SAY** as follows:

1. I am Sophie Alderman's mother, and I make this statement in response to a request for my evidence under Rule 9 of the Inquiry Rules dated 10 February 2025 and in relation to my daughter's death on 19 August 2022.

2. At the time of Sophie's treatment under Essex mental health services, I was not in contact with Sophie although she did speak to her dad, my partner (her stepdad) and her little sister. I learnt of Sophie's treatment under Essex mental health services and the circumstances in which she died through Sophie's inquest proceedings and the Trust's internal investigation. This is information that I learnt only after Sophie died. My Solicitor has helped me prepare this statement and she has reminded me of relevant evidence that I have either read in preparation for Sophie's inquest or heard during the eight day hearing I attended daily.

Diagnosis

3. I have set out in chronological order as much information as I can about Sophie's health history and when she has been diagnosed with various mental and physical health conditions.

<u>Sophie's childhood</u>

4. The first signs of Sophie's health difficulties were when she was in the junior stage of primary school. She was about 8 years old when she began to experience blackouts sporadically, where she would just drop to the floor unconscious. She was medically assessed, but this did not lead to any diagnosis. These were neurological tests. We

took her to our family GP when it first began to happen, and she was referred to the hospital where they monitored her brain activity. The results came back and there were no abnormalities. The conclusion was that Sophie was experiencing what doctors referred to as 'psychologically-led black outs'.

5. Sophie was about 7 when her granddad (my dad) passed away. They were close. Not long after he died, Sophie's dad and I initially separated. I recall clinicians drew a link between these events and the psychological impact this may have had on Sophie. Within a year, lots had changed for Sophie, and it was the middle of the separation she developed black outs and sleepwalking. Professionals referred to Sophie being anxious and this causing the black outs and sleepwalking around that time. However, she was not diagnosed with anxiety or any other conditions at this time.

6. Towards the end of August 2009 Sophie, aged 14, developed pneumonia from a bad cold when she was staying with her dad and brother over the summer holidays. Sophie was hospitalised for around a week and then she was off school for at least couple of weeks, right at the start of term. In total I think it took around six weeks for her to make a recovery. She initially went in for half days before returning to school full time. It was a really nasty illness, and I believe this caused her more anxiety, particularly missing the early weeks back to school when other pupils would have been settling back in.

7. I am not sure if she developed asthma as a result of the pneumonia or whether we discovered she had asthma once she was hospitalised with pneumonia, but she was diagnosed with it at this point.

<u>First contact with Child and Adolescent Mental Health Services ('CAMHS') in 2009</u>

8. It was towards the end of that September or beginning of October 2009 that I was contacted by a school counsellor who told me that Sophie had gone to her and said she had been self-harming and that there was evidence of it on her arms. She understood this in the context of Sophie feeling very anxious. We took Sophie to our GP, and we discussed anti-depressant medication. I was very apprehensive about Sophie being medicated at such a young age and I expressed that I did not think this was suitable. Sophie then independently visited the GP shortly after our appointment and she was prescribed the medication.

9. My understanding is that Sophie was referred to the Child and Adolescent Mental Health Service ('CAMHS') as a result of us attending the GP and that they may have had contact from Sophie's school at the same time.

10. Sophie never spoke directly to me about her struggles at this stage, and it was only through her school that I learnt about this self-harming.

11. I understand that Sophie reported later in life to treating professionals that she was raped when she was 12 but some EPUT records refer to her being 15. I did not know about this at the time, I do not know how old she was when this happened, and I only learnt information from Sophie and others about it much later in life. Sophie having been raped when she was 12 was included in an incident and risk assessment of Sophie completed by EPUT when she first came under their care in 2022. In other records about Sophie, EPUT referred to her having been diagnosed with PTSD as a result of this experience, and in a couple of other records EPUT refer to her being 15 when she was raped. I do not have any personal knowledge of Sophie having been diagnosed with PTSD, by who or when.

12. When Sophie came under the care of CAMHS this was the first contact she had with mental health services. She was quickly diagnosed with Anxiety once she was referred to CAMHS but I do not believe she was diagnosed with anything else.

Adolescent years: 2009 – 2014

13. Sophie's mental health between the ages of 14 and 18 would improve and decline in 4-6 week increments whilst she was under the care of CAMHS. Those peaks and drops sometimes coincided with her medication. I think Sophie's antidepressants for anxiety initially worked well for her and she would be absolutely full of life and ambition. She would tell you, 'right I'm doing this or going to this place', just be really social and kind of what you would expect from a teenager, but it was also exhaustingly manic. She would then come off the medication telling me that she was fine and did not need it and then have an episode and spiral back down. In response, she would either be put on a higher dose of the same medication or a new medication altogether. While she was adjusting to that change, things would be really rotten again.

14. There was no predictability on the medication front. Certain medication made life more manageable for Sophie while others could have the complete opposite effect. In hindsight, knowing how things worsened on this front, at least at this age Sophie only had one type of medication. This may have meant she spiralled less than she did in adulthood when she was later prescribed a cocktail of drugs. I do not know the names of the medication she took over this period, I know it changed but I believe it was always one form of anti-depressant capsules.

15. I recall that when Sophie turned 18 in June 2013, she was discharged from CAMHS back to her GP with a letter. I can't remember there being any discussion about transition to adult services or support once she was discharged from CAMHS. I do remember it felt like the local services just washed their hands of her once she was an adult. I have looked through the records that I still have from before Sophie was under the care of Essex services, but I've been unable to find this letter or any records which would help me provide the Inquiry with an outline of what happened when Sophie was discharged from CAMHS.

16. I do not have any memory of services involved in Sophie's care from this point, other than her GP. I am aware that Sophie's GP records, disclosed in preparation for her inquest, refer to her being diagnosed with a Borderline Personality Disorder on 12 November 2014 but I do not have any knowledge of this. From memory all I recall is that the 4-6 week fluctuations of her mental health intensified into adulthood and her mental health worsened after she was discharged from CAMHS.

Adulthood and inpatient care: 2015 – 2021

17. A major turning point in Sophie's mental health was in June 2015, when she was 19 years old, days before her 20th birthday. My friend and I took her to A&E in a Southern Health NHS Trust hospital which was close to where we lived, because she reported she was having thoughts and hearing voices to harm people that she did not want to act on. It was only around this time that I learnt that the voice Sophie was hearing was named 'Shona' and that this was a real person for Sophie. Sophie's GP records suggest she was diagnosed with a psychotic disorder during this admission but I have no more information than that. Sophie was then transferred to a residential care home, Natalie House, on 15 June 2015. This is a CQC regulated 24 hour residential care home in Southampton.

18. Between 2015 and 2021 Sophie was regularly detained in Southern Health NHS Foundation Trust mental health hospitals, mainly Trinity Ward in Antelope House. This is an acute mental health care inpatient unit in Southampton. When she was not in hospital, she remained at Natalie House. We agreed with treating professionals that she was not able to come home because she would not be safe without that level of care.

19. It was during this time that Sophie was diagnosed with Emotionally Unstable Personality Disorder ('EUPD'), OCD and Schizoaffective Disorder. I do not have any direct knowledge of what she was diagnosed with, when or by who but I understand from Sophie's EPUT medical records that she had a diagnosis of EUPD by 10 June 2016 and that she was diagnosed with Schizoaffective Disorder on or around 25 January 2021. Sophie's GP records suggest that she was diagnosed with PTSD, a depressive disorder and OCD by 9 December 2021.

20. Sophie suffered throughout this time with intrusive thoughts; she heard voices to harm people, and she would express suicidal thoughts. Sophie was known to self-harm and she would do this impulsively. I know Sophie would quickly feel remorse after she had done something dangerous or self-harmed. Despite the struggles Sophie had with her mental health, Sophie never wanted to die. She expressed to me on multiple occasions that she did not want to die but that she just wanted the voices to stop. I felt that Sophie used self-harming to soothe or distract herself from the intrusive voices and thoughts.

21. Summaries of Sophie's records between 2015 and 2021, contained in EPUT contemporaneous medical records disclosed in preparation for her inquest, set out multiple incidents of self-harm or self-reported suicidal thoughts. Forms of self-harm used by Sophie included burning herself **[I/S]** walking into traffic, overdosing on medication (on at least 3 occasions), scratching or cutting her arms, and ligaturing. The same records also reflect that these were often impulsive acts of self-harm followed by a lot of remorse. Sophie was often able to bring herself to the attention of emergency services as and when these experiences happened during this time. She was open with services when she was experiencing auditory hallucinations and urges to harm herself. She often reported that she felt or saw bugs crawling under her skin, which would also trigger acts of physical self-harm.

22. At some point in 2016, I remember that Sophie developed Neuroleptic Malignant Syndrome (NMS) whilst she was on Trinity Ward, Antelope House. She was taken to

Southampton General Hospital and had to be placed in an induced coma, which was a really frightening experience for her. I was told by those treating her at the time that this had been caused by the anti-psychotic medication that she was taking. I understand from the records received in preparation for Sophie's inquest that she first developed NMS when prescribed Depixol, and again when she was switched to Quietiatapine. This was contained in EPUT medical records created at time Sophie was under their care, so they were aware of this. I took from this at the time that a lot of strong anti-psychotic medication was probably unsuitable for Sophie. I don't believe Sophie referred to feeling bugs crawling under her skin until after this experience. I also know from Sophie's GP records that she even had an adverse reaction to codeine, which led to suspected hives but I do not know when this happened.

23. I am aware that shortly after Sophie was hospitalised in Basildon Assessment Unit, which was the first time she came under the care of Essex Mental Health services, treating clinicians obtained confirmation from South Health NHS Trust on 9 May 2022 that Sophie was diagnosed with schizoaffective disorder, OCD and EUPD. They also had a detailed summary of her care history in Southampton, which included her history of multiple admissions on to acute mental health care inpatient units.

24. It was apparent during this time that Sophie seemed to particularly struggle around big life events, like her birthday and mine. This was illustrated by her first admission into in-patient care in June 2015 and it is also illustrated by medical records obtained by EPUT. For example, she was admitted to hospital for treatment for her mental health in close proximity to her June birthday in both 2019 and 2020.

Assessments, admissions, wards, care plans and discharges

25. I am aware of the following events solely from records disclosed in preparation for Sophie's inquest, and from evidence given at that inquest because I did not have any direct contact with Sophie whilst she was under the care of Essex mental health services.

<u>Move to Essex in 2022</u>

26. Sophie moved to Essex with her then-boyfriend on 28 March 2022. I understand that by that point Sophie had been admitted into mental health hospitals 21 times. She was

considered a "revolving door" patient as a result – a term used by EPUT's Consultant Psychiatrist, Dr C when he provided oral evidence during Sophie's inquest.

27. Sophie registered with East Hill GP surgery in Colchester on 6 April 2022. She also came to the attention of the Colchester Mental Health Single Point Access Team in April 2022. I believe, based on Sophie's records, that this followed a referral from her GP on 7 April 2022. [I/S] (RMN), acting as a Primary Care Network Clinical Lead of EPUT, queried in emails disclosed to me in preparation for Sophie's inquest, whether they would be transferring the care for someone in receipt of a CPA ('Care Programme Approach' typically a package of care used by secondary mental health services), and the RMN suggested it should go to "*secondary care for review in the first instance re her complex needs and medication regime*."

28. [I/S] the Registered Nurse Mental Health Practitioner of the North Essex Single Point of Access Primary Care Mental Health Team, replied that it was not a transfer of care, and that the GP did not have any record from previous mental health services Nurse Practitioner asked if Sophie's case should be allocated for a routine assessment with a community team. The RMN replied *"well, I'm not sure it's just her medication is very complex, I'm not sure what I would offer apart from a brief review – sounds quite complex for primary care"*. Despite this, the team wrote to Sophie on 22 April 2022 and asked her to contact them if she wanted an appointment – their standard 'opt in' letter for a routine assessment.

Assessment in community

29. On 25 April 2022, Sophie was seen by the Crisis Resolution and Intensive Home Treatment (CRHT) team in Colchester. She reported that she was experiencing symptoms of psychosis, including auditory hallucinations and thought insertions. Sophie said that she believed the government was monitoring her, her social media accounts were hacked and depot injections contained live bugs created by the government, injected into her skin to monitor her. She reported that she had been on a depot injection but she had not taken it since February 2022, and that she had recently started aripiprazole (an antipsychotic medication) with her current GP. She disclosed that her mental health had been declining over that last month.

30. [I/S] of the CRHT, under the management of [I/S], was initially allocated as her social worker and he was involved in a risk assessment as part of Sophie's care planning on 26 April 2022. He identified the following risks:

    i. Suicidal ideation (including reference to ligaturing)
    ii. Self-harm
    iii. Violence and aggressive behaviour
    iv. Evidence of neglect

31. It was agreed that, at least according to Sophie's medical records, Sophie would be supported through her current crisis and that she had agreed to work with the CRHT because she did not wish to be admitted into hospital. There was no further detail about how all of these risks would be managed in practice, and I am concerned that this plan was setting Sophie up to fail because there was so little consideration of practical steps that would be taken to support her.

32. Over the following days it is apparent that Sophie spiralled further. She contacted the Home Treatment Team repeatedly and disclosed paranoid and intrusive thoughts. During a home visit on 28 April 2022, the records show that Sophie was reporting ongoing paranoia and suicidal intent. She was advised to go to A&E as a last resort if she felt unsafe. Looking back, I do not know why the decision was not made to detain her for treatment at that stage, given the rapid deterioration in her condition over the preceding days.

33. By around 10:25am the following day, on 29 April 2022, Sophie had presented herself to the Emergency Department of Colchester General Hospital where she was accepted as an informal patient. It appears from the records that she remained in the Urgent Treatment Centre until an inpatient bed had been identified.

<u>First admission to Basildon Mental Health Assessment Unit (EPUT)</u>

34. The next day, on 30 April 2022, Sophie was transferred to Basildon Assessment Unit, an EPUT ward. I now know from disclosure made for Sophie's inquest that her initial assessment of needs and risk was not fully completed on her admission. Sophie's medical records are also contradictory about her status on that admission because they say that she was admitted informally but also that she was detained under section 5(2) of the Mental Health Act (MHA) 1983. Witness evidence provided by Sophie's

Consultant Psychiatrist during that admission, Dr **A** indicated that Sophie was initially admitted as an informal patient, and then detained under section 3 MHA 1983.

35. I learnt during Sophie's inquest that, at some point during Sophie's admission, Dr **A** phoned Southern Health Trust NHS mental health services in order to obtain information about her treatment there, and her diagnoses. He said in evidence that he received a *"long document"* about Sophie's past engagement with services in Southampton.

36. Sophie was placed on level 2 observations due to her presenting risk. I understand from EPUT's policy documents disclosed during preparation for Sophie's inquest that this meant that she should have been visibly checked on at least 4 times an hour.

37. On 1 May 2022, Sophie underwent an admission assessment by Consultant Psychiatrist **Dr B**. Sophie reported in great detail her ongoing symptoms, and how they had worsened recently. She described symptoms which amounted to paranoid ideation, poor sleep, audio and visual hallucinations. She described seeing and hearing a shadow she believed was acting on behalf of the government, and displayed compulsive behaviours such as tapping. She also said that she believed the depot injections she had been receiving previously contained bugs created by the government which were injected into her to report back her position. She stated that she planned to kill herself in order to escape the government.

38. Sophie asked to self-discharge repeatedly during the assessment. Dr **B** decided to detain her under section 5(2) MHA 1983 for a full mental health assessment. Her care plan was completed the same day, which noted the following risks:

    a. Suicidal
    b. Deliberate self-harm / harm to others
    c. Deterioration in mental state
    d. Hearing voices

39. In respect of Sophie's views the plan provided:

    "Sophie would like improvement in her mental state whilst on the ward and in the community. She is aware that she can approach staff on the ward for

support and assistance when required and that she will be supported, offered assurance and one to one session with staff and also her safety maintained whilst on the unit."

40. Sophie's strengths were identified in the following terms:

"Sophie currently has insight into her emotional and mental health and she understands that she needs support.

Sophie is able to express her needs and concerns whilst on the unit.

Sophie is able to engage with staff when required support and assistance.

Sophie has capacity and was willing to engage with the mental health service."

41. The care plan noted that **[I/S]** was her allocated named nurse and that her care plans would be reviewed after every ward or MDT meeting to reflect her current risks, medication review and observation levels.

42. Sophie had separate care plans for her mental health and physical needs. At that stage Sophie's mental health planned outcomes were:

a. For Sophie's mood and mental state to be improved and stabilized through assessment and treatment
b. Sophie to be encouraged to engage with the therapy team to learn coping and distraction techniques to help deal/manage her self-harming behaviours
c. Stop taking overdose of medication
d. Staff to engage and observe to assess mental health state
e. To be nursed in a safe environment
f. For staff to engage with Sophie and make sure she is safe at all times
g. Reduce thoughts and risks to self-harm or end life
h. For Sophie to be compliant and benefit from prescribed medication whilst on assessment unit
i. Reduce or eliminate hallucination / hearing voices symptoms or presentation
j. Ensure Sophie's sexual safety and for her privacy and dignity to be maintained
k. For staff to gain better understanding of Sophie's needs

43. I pause here to note that one of Sophie's mental health planned outcomes was for her to engage with "*the therapy team to learn coping and distraction techniques to help deal/manage her self-harming behaviours*". This remained on her care plan for her mental health needs throughout her first admission in Basildon Mental Health Assessment Unit. I do not have any information about who was in this therapy team at the time and I have not seen any evidence from Sophie's records that Sophie received any therapy whilst she detained in Basildon Assessment Unit. There is certainly no evidence that she was allocated a psychologist or received any therapy following incidents of self harm. The care plan does not mention Sophie's agreement or views on these planned outcomes.

44. On 2 and 3 May 2022, the records indicate that Sophie had episodes of head banging, and reported to staff that she was experiencing paranoid ideation about government monitoring, including that she had spy devices all over her body, and about staff and other patients *"stealing her thoughts"*. In answers to questions at Sophie's inquest, Dr **A** agreed that head banging was a *"risk behaviour indicative of increased agitation and distress"*, which *"requires staff intervention and monitoring"*.

45. On 3 May 2022, at a ward review, Sophie told staff that she believed government officials were posing as patients, that there were cameras in their eyes, and that the camera in her room was being monitored by the government. I understand that the reference to the camera in her room is likely to have been a reference to the Oxevision system, which I understand is installed in bedrooms on EPUT wards. Sophie was deeply uncomfortable around cameras from a young age, so it does not surprise me that she was so concerned about a camera system being present in her room. Even as a child she hated her photograph being taken and she would shy away from cameras. During Sophie's early admissions into mental health units in Southampton, one of the first things I remember Sophie would ask is 'where are the cameras?' Back then it was just some CCTV cameras in corridors. There were no cameras in bedrooms. But Sophie would want to know exactly where those cameras were.

46. As illustrated by Sophie's medical records, Sophie's paranoia or psychosis often presented as distressing fear that she was being tracked, followed or spied on by the government or another third party without her consent and for the purpose of causing harm to her or her family. It follows that Sophie would typically be anxious about cameras or very mistrustful of them.

47. Later the same day, Sophie used a piece of clothing to ligature, and she was escalated to Level 3 observations, which I understand are constant 1:1 observations. I understand it was particularly serious because it was noted in Sophie's records that she was discoloured in the face by the time that she was found. It was recorded in an inadequately completed Datix Incident Report that Sophie's bed area was stripped from items of clothing in response to this, but there is no reference to this happening in other records.

48. A pattern of Sophie head banging, reporting increased paranoia and/or agitation and later tying ligatures stood out to me from the records because, as I discuss below, it was sadly reflected on the day of her death. I believe that treating professionals should have updated her care plan and risk assessments to reflect this as a risk indicator for Sophie. From the records disclosed in preparation for Sophie's inquest, it does not appear that this happened.

49. Sophie tied another ligature on 6 May 2022 using a black cotton cord. Sophie's records state that all items deemed to be ligature items were then removed from her room. I do not understand why she still had those items after ligaturing on 3 May. She had said the day before that she wanted to *"end it all"* and that she did not want to be saved. From the records disclosed in preparation for Sophie's inquest, it does not appear that her care plan or risk assessments were updated following this ligature attempt either.

50. Sophie's observations were increased to Level 4, which I now understand means a staff member must be within arm's length at all times.

51. On 8 May 2022, Sophie told staff that she believed the government had a camera in her room, and used flash lights to send her morse code, telling her to kill people. She presented as tearful and agitated and pleaded to leave the ward. Again, I believe this is likely to be a reference by Sophie to the Oxevision system in her room having seen a photo of the system, with its lights. It suggests to me that she found the presence of the camera distressing, and that it was feeding into her paranoid ideas.

52. On 9 May 2022, Sophie was seen in an MDT review where she told staff that the government was asking her to kill herself, that she was pregnant with an alien baby, and that she would hang herself. She also believed that Dr **C**, her Consultant Psychiatrist and Responsible Clinician, had directed the nursing staff not to switch lights off to make her uncomfortable. I believe this, again, may have been a reference to the lights on the Oxevision system in her bedroom.

53. Sophie told staff that banging her head on the wall kept the voices quiet. Sophie's care plan was not updated to reflect the fact that head banging was a coping mechanism for her when she was in distress, and a sign that she was not doing well. As I discuss below, this is particularly concerning for me because Sophie was seen by staff head banging shortly before she fatally ligatured only three months later.

54. A recommendation was made for Sophie to be detained under section 3 MHA 1983 and she was assessed and detained on 10 May 2022. The notes of the assessment state that she had tried to ligature twice the previous day, but the records provided for Sophie's inquest do not include reference to any ligature incidents on 9 May 2022. There are also no Datix Incident Forms that have been completed. This makes me very concerned about the accuracy and reliability of Sophie's medical records because I cannot understand how something as important and life threatening as a ligature attempt – let alone two – cannot have been recorded by staff.

55. On 11 May 2022, the records suggest that Sophie reported paranoid thoughts about a new patient on the ward, and had been observed by staff as not taking care of her personal hygiene. Her care plan was updated on 11 May and 12 May 2022, but the content did not appear to have changed significantly from the first care plan on 1 May 2022.

56. On the night of 12 May 2022, Sophie ligatured **with clothing** and the records state that once again all ligature items were removed from her room. There is no record of ligature items being returned to Sophie since her last recorded ligature incident on 7 May 2022, when they were apparently removed. I do not understand how Sophie still had access to items she could ligature with when they were meant to have already been removed, and there was no record of them being returned.

57. On 16 May 2022, Sophie became what was described as 'very agitated' due to noise, and a fire alarm sounding in the ward. Sophie was always noise sensitive, even as a small child. It was common in my experience of Sophie for her to be distressed or agitated by loud noises and commotion.

58. On 23 May 2022, Sophie started to be administered Clozapine, a strong anti-psychotic medication used for treating schizophrenia, which she had requested.

59. On 26 May 2022, Sophie reported to clinicians that she felt that her new medication was "*kicking her ass*", that she was dribbling from her mouth, that she felt like her legs were floating and that she was light headed. In the same record it is noted that Sophie complied with medication "*with no side effects observed*".

60. On 27 May 2022, after presenting as agitated during the day, which was attributed in the records to her frustration at still being on the assessment unit rather than a treatment ward, Sophie ligatured **with clothing** Her observations were increased to 2:1. The notes for the incident record that Sophie said repeatedly that she had nothing to live for, and did not feel the assessment unit was therapeutic for her. There is no discussion in the records of why Sophie did not feel the unit was therapeutic. I can only hope that this was something staff engaged with her about, to understand why she was feeling that way, but there is nothing in the records that suggests that they did. There was also no Datix Incident Report completed.

61. The following day, during a medical review, Sophie's observation levels were lowered again to 1:1. She said again that she did not feel she could get better on the assessment unit. Again, the records do not address why she felt that way. It seems very soon after Sophie's last ligature attempt to have reduced her observation level.

62. On the same day Sophie was prescribed Hyoscine Hydrobromide in response to her further complaint that she needed something to stop her dribbling. Sophie also reported that she could not feel her body or keep her eyes open. I assume that these were also ongoing physical side effects she was experiencing from taking Clozapine.

63. On 29 May 2022, Sophie's care plan was updated. Again, this appears to be almost identical to the earlier care plans, and no mention is made of Sophie's ligatures on the unit, or any of the potential risk indicators, like head banging, or increased intolerance of staff or other patients. Her initial assessment of needs and risk was also reviewed the same day. There was no mention included of any of her potential risk indicators.

64. On 30 May, Sophie complained to staff that she had ulcers on her right ankle, which she said had developed while she was sitting in the garden cross-legged and it was causing her pain. She was examined by Dr **[I/S]** and it was observed these were three small lacerations on her "*lateral malleolus*". I have seen no evidence of any further consideration or investigation as to what caused these lacerations.

65. During an observation review on 31 May 2022, Dr **A** in response to Sophie saying that she was frustrated about the delay in being transferred to a treatment bed, told her that patients could be refused if they were unsettled, and that her high level of observations may prevent her getting a treatment bed. Dr **A** asked Sophie if she would "*work with them to prevent an incident*". Sophie said that she still had thoughts to hurt herself, but wanted to go to a treatment bed more, and would try to keep herself safe. In response Dr **A** told Sophie he wanted to lower her observation levels to level 3 and then eventually to level 2. Her observation levels were reduced to level 3 again.

66. It seems questionable to me that the prospect of a treatment bed was used to encourage Sophie to resist self-harm rather than focusing on the root causes or triggers of why Sophie had been engaging in risky behaviour. I worry that this was just an invitation to Sophie to mask how she was feeling, which is particularly concerning to me because Sophie's ability to express when she was struggling was identified as a strength in her care planning – it had helped to keep her safe.

67. Sophie's care plan was updated again on 31 May, 2 June and 6 June 2022. Once again, it does not appear that much in the way of new information was added on these occasions.

68. On 6 June 2022, Sophie had another observation level review, where Dr **A** agreed to lower her observations to level 2 after Sophie reported that whilst she was still struggling and hearing voices, she felt her agitation had decreased. It was agreed on the same day that Sophie's daily maintenance dose for Clozapine would be 325mg: 150mg morning and 175mg at night. Sophie's medical records state "*feels bugs under her skin (she would self-harm but has not been doing so)*".

69. On 7 June 2022, **[I/S]** was allocated as Sophie's care co-ordinator. She had a phone call with Sophie on 9 June where they discussed Sophie's desire to leave hospital as soon as possible, and her need for accommodation, as she had split with her ex-boyfriend shortly before her admission to hospital.

70. The same day, Sophie was seen by Dr **A** and his team who explained that as her GP was registered in Colchester, she would need to register with one in the Basildon area to ensure she was allocated a care coordinator in the Basildon community. It was said that Sophie had googled GP surgeries that she could join.

Sophie informed the team that she did not have a *"desperate urge to kill herself"* but reported that everything had been the same for the last 6 years and she wanted to go home now.

71. The next day, on 10 June 2022, during a ward round, Sophie told staff that she had low mood and was still hearing voices, but that this issue was chronic and had been with her a long time. Dr A told her he would rescind her section that day, and Sophie agreed to remain on the ward for the discharge CPA meeting on 13 June 2022.

72. Sophie also had a Teams meeting with her care co-ordinator who wanted to gather more information about her case before a planned CPA meeting on 13 June. Her care co-ordinator noted that there was limited information on their system about Sophie, and that Sophie was reluctant to answer most questions.

73. A risk assessment completed for Sophie the same day noted that she remained at high risk of accidental and deliberate harm, and a medium risk of suicide. It referred to the risk of hanging, but did not reference any of her recent ligature attempts on the unit.

74. The CPA meeting took place on 13 June 2022, as planned, and her discharge plan was agreed as follows:

    a. Crisis team 48 hour and 7 day follow up on discharge
    b. Bloods to be taken that day
    c. Community Consultant in Colchester to prescribe Clozapine until Sophie was transferred to the care of the Basildon team
    d. Sophie was to register with a GP urgently once discharged
    e. The Care Coordinator from the Colchester community team was to remain the key contact until the case was transferred to the Basildon team
    f. The Clozapine Clinic in Basildon agreed to dispense medication to Sophie
    g. Sophie's Care Coordinator was to consult with the Colchester Community Consultant to ensure repeat prescriptions were supplied to the Basildon Clozapine Clinic

<u>Failed discharge and care in the community</u>

75. On 15 June 2022, Sophie was discharged with a supply of her medication. I discuss my concerns about Sophie's medication further below, but the volume of medication she was discharged with – 7 days' supply of around 12 different medications – staggers me. Not only did Sophie have a history of non-compliance with medication, but she also had a history of taking overdoses of her medication. It strikes me as very risky to discharge someone with that sort of history, and who you have assessed only a few days earlier as still at high risk of suicide, with such dangerous quantities of medication.

76. On 15 June 2022, Sophie's care coordinator requested details of her section 117 aftercare needs, but was told by the discharge nurse that, having discussed with Dr **A** and an individual referred to only as **[I/S]**, the only thing Sophie was considered to need to support with was her prescription of Clozapine.

77. I do not understand how this conclusion had been reached. It seems to me reading through Sophie's care plan that almost all of the support for her was contingent on her registering for a new GP in her new local area, but no provision was made to support her with this. Sophie had a long history of poor compliance with medication when discharged from hospital – she reported paranoid ideation about her medication, including beliefs that her injections were being used by the government to track her. Again, Sophie was being set up for failure. It is unacceptable that enquiries about Sophie's aftercare needs were only being made the day she was due to be discharged from the ward. I heard repeatedly at Sophie's inquest that discharge planning is meant to begin from admission onto a ward, which was far from Sophie's experience.

78. Dr **A** said in his evidence for Sophie's inquest that Sophie was ready for discharge because *"there was a notable improvement in her presentation"* and she therefore no longer needed admission to a treatment bed. Dr **A** stated that Sophie had been complaint with medication, and he had seen an improvement since her prescription of Clozapine. Sophie's last incident of self-harm on the ward was on 28 May – barely two weeks before she was discharged – and took place while she was on Clozapine. Her dose of Clozapine was not settled at the time, and it was being increased by Dr **A** in order to *"optimise the dose"*. As I discuss further in the Medication section of my statement below, Sophie appears to have been suffering adverse side effects from the medications she was taking, and despite this her dose was being increased. She was still being assessed as high risk to herself, and she was still reporting hearing voices. She was being discharged into the community with local support contingent on her taking independent steps to register at a GP.

79. I believe it should have been obvious to treating professionals that Sophie was not ready for discharge and particularly not for such an unsupported and dangerous discharge. I have been really concerned by the selective portrayal of Sophie's condition by professionals like Dr A, willing to rely on a very small and selective snapshot, rather than being prepared to look at the bigger picture. This is underscored for me by how rapidly and seriously she then deteriorated in the community.

80. On 16 June 2022, the Care Coordinator completed a care review and care plan for Sophie which listed early relapse indicators for her, including:

    a. Increased anxiety relating to people reading her thoughts and controlling her feelings;
    b. Increased voice hearing;
    c. Social withdrawal: low mood, refusal to leave the house, and self-neglect; and
    d. Low appetite.

81. The following day, on 17 June 2022, Sophie had a video assessment from her supported accommodation in Basildon. She reported that she had been borrowing money from friends as she had no food, but reported preferring the accommodation to hospital. Her risk assessment was amended to now state that her risk of suicide, self-harm, and disengagement with treatment were all low risk.

82. On 20 June, Sophie told the Care Coordinator that she had not registered with a GP because she had not been able to go out. Given the importance placed in Sophie's discharge plan on her registering with a GP, I think this should have been a real red flag, but all that followed from Sophie saying this was an agreement that Sophie would try the following day to register. I do not understand why the CC or another professional could not have taken steps to register Sophie, or accompanied Sophie to the GP to ensure she did register or arrange for this support. Most importantly, refusal to leave the house, and social isolation, were known early warning signs for Sophie – the CC had written them into her care plan just 4 days previously.

83. On 21 June, Sophie was delivered a further week supply of Clozapine. A decision was made to provide Sophie with more medication despite her known history of overdoses, and the warning signs in her presentation just a day previously. Meanwhile, the only aftercare Sophie was meant to be receiving according to Dr A was said to be

support with her Clozapine, but beyond delivery of the medication I have seen no evidence of this support in practice.

84. On 22 June, Sophie had a phone call with the CC again where she reported that she had no appetite, had not been eating, had not been taking her medication, and was hearing voices telling her to kill paedophiles, and not to register with the GP as the government would be able to track her. She said that she wanted to be left alone. The CC recognised that Sophie was showing signs of a relapse, and made a referral to the Approved Mental Health Professional (AMHP) service.

85. Sophie was assessed the following day on 23 June 2022 by Dr D Dr [I/S] and [I/S] (AMHP). Sophie said that the voices she was hearing were worse than when she had been hospitalised, she was not taking her medication, and that she wanted to die. She said that she had tied a ligature in the morning with her dressing gown cord, and that ligaturing *"makes me feel better for a while"*. She told the assessors that she had lied the week before to the hospital when she said that she was feeling better, so that she would be discharged.

86. From the records, it appears that the assessors initially agreed that Sophie should be detained under section 3 of the Mental Health Act. AMHP then contacted bed management to request a bed for Sophie, but was told none were available, and was later advised that one was unlikely to become available that evening. She remained with Sophie for several hours and spoke to her further. AMHP stated in her witness statement for Sophie's inquest that, following those conversations, Sophie said that she had taken her medication that day, and that she wanted to engage with support from the Home Treatment Team and take her medication. As a result, AMHP contacted the two doctors and a decision was taken not to detain Sophie.

87. AMHP said that she agreed a "*safety plan*" with Sophie, which consisted of Sophie calling 999 if she was at immediate risk, 111 if she felt unable to cope at night, or attending A&E. AMHP stated that the plan was that Sophie would receive support from the Home Treatment Team and from her care co-ordinator. This plan appears to me to be very limited, and it did not actually do much, if anything, to keep Sophie safe. It is largely contingent, once again, on Sophie proactively taking steps to keep herself safe – as was the case with her discharge plan which relied upon her registering for a local GP, which she had already failed to do.

88. Sophie told her care co-ordinator, [I/S] the following day that she had not been detained because no bed had been found. I am still concerned that these are two very different explanations for why Sophie was not detained as originally planned, and to date there has been no explanation provided to me for why this was the case. If the decision not to detain Sophie did arise from the lack of available bed, as her care co-ordinator was told, this would be hugely worrying for me, particularly because it would appear that a more palatable explanation had then been manufactured after the fact. I am also concerned that although the "*safety plan*" relied on Sophie's care co-ordinator providing her with support, her care co-ordinator was not advised of this, or of the decision not to detain Sophie, until she phoned Sophie herself a day later.

89. In that call, Sophie also said that she had still not registered with a GP, had been told that there was no bed for her, and that she was feeling low and still hearing a voice telling her not to register with a GP. She said that she did not want to take any more medication.

90. The CC says that she then had contact with the AMHP who also said that a bed had not been found for Sophie and that Sophie had agreed to take her medication and be treated by the Home Treatment Team. The CC expressed that it was difficult for her to offer support to Sophie because of the geographic distance between them – the CC was in Colchester while Sophie was in Basildon. The CC said in her witness statement for the inquest that *"my professional view from my discussions with Sophie was that she needed to be admitted for her own safety"*. The CC 's supervisor, who was also a qualified AMHP, contacted the AMHP team to reiterate those concerns.

91. On 25 June 2022, the Home Treatment Team visited Sophie, who was seen to have tied a ligature [I/S] was evasive when discussing her medication compliance, continued to report hearing intense voices telling her to kill herself and others, and stated that she was intent on killing herself after her birthday, which was the following day. As I have mentioned above, Sophie always struggled with her mental health around big life events like her birthday and mine. Sophie was also seen to have cuts on her hand which she said were from trying to dig out bugs that had been inserted into her body when she attended the Clozapine clinic for blood tests. Sophie reported using ligatures as a means of quieting the voices she heard. The Home Treatment Team decided that her risk level was too high to be safely managed in the community. A Mental Health Act assessment followed.

92. The assessing team had gathered information from the Southampton Crisis Team about Sophie's case, and spoke to her care co-ordinator, and her father. They recommended that Sophie be detained under section 3 MHA.

Admission to s136 Suit, Rochford Community Hospital

93. Sophie was taken to the section 136 suite at Rochford Hospital on 25 June 2022. She was assessed and detained under section 3 MHA.

94. Sophie was assessed as at high risk of suicide, accidental harm and misadventure. She was assessed as at medium risk of deliberate harm (such as cutting herself), and violence to others. She was initially placed on level 3 observations.

95. It was decided that Sophie would be transferred to Basildon Assessment Unit and noted she would need a referral for treatment of an ankle injury.

Transfer to Basildon Mental Health Assessment Unit

96. The following day, 26 June 2022, was Sophie's birthday and she was transferred to Basildon Assessment Unit at about 5:30pm.

97. Sophie complained about her ankle, which was described in Sophie's records as a wound, swollen, weeping pus, and causing her pain.

Ankle surgery – Basildon General Hospital

98. Dr **[I/S]** (CT1), the duty doctor on Basildon Mental Health Unit, wrote a referral letter dated 26 June 2022 for Sophie's ankle to be assessed, referring to it as "*swelling over [Sophie's] right malleolus and redness and redness about 5*7cm.. ooze[s] pus and blood.*" Sophie was taken to the Accident and Emergency department of Basildon General Hospital at around 9:45pm.

99. Sophie's care plan was updated on 27 June 2022, whilst she was in Basildon General Hospital, stating that she would be nursed on level 3 observations and outlined the following aims:

a. For Sophie's mood and mental state to be improved and stabilised through assessment and treatment
b. To engage and observe to assess mental health state
c. To be nursed in a safe environment
d. For staff to engage with Sophie and make sure she is safe at all times
e. To reduce risk of self-harm and end life
f. For Sophie to be compliant and benefit from prescribed medication whilst on assessment unit
g. To reduce or eliminate hallucination / hearing voices symptoms or presentation
h. To ensure Sophie's sexual safety and for her dignity and privacy to be maintained whilst on assessment unit
i. Reduce Sophie's violence and aggression
j. For staff to gain better understanding of Sophie's needs
k. To work towards discharge from time of admission

100. Despite the fact that Sophie had been detained under section 3 MHA, the care plan continued to state that she was an informal patient. Once again, much of the care plan does not appear to have been amended from previous drafts. However the aim of Sophie engaging with the therapy team and learning coping and distraction techniques to help deal or manage her self-harming behaviours was removed. I do not know why this decision was made but it was a permanent amendment to Sophie's care plan for the remainder of her life under the care of EPUT.

101. There is some inconsistency in the records about whether Sophie was being observed on level 2 or level 3, until 29 June 2022 when it appears she was consistently being nursed on level 3 observations. I am angered by the inconsistencies, errors and missing information in Sophie's records. Without accurate and complete information about Sophie, I do not understand how staff expected they could keep Sophie safe, or to make decisions about her care.

102. Sophie was given antibiotics in Basildon General Hospital and told on 27 June 2022 that she would require surgery. Sophie's records reflect that she was really distressed by the prospect of surgery. She tried to escape the hospital and went back towards Basildon Mental Health Assessment Unit. She was observed to be crying and hyperventilating and in reference to her IV cannula said: "*they've put things inside my skin*." I do not believe there was any meaningful appreciation or consideration of

Sophie's history of medical trauma and associated paranoia which may have been heightening her fears.

103. Staff got Sophie back to Basildon General Hospital by warning her that she needed the surgery to save her leg and that not having it done would lead to the risk of sepsis and possible amputation of a limb. I do not think this was a helpful way to encourage Sophie's compliance with their requests.

104. Sophie underwent the relevant surgery at Basildon General Hospital on 28 June 2022.

105. It is not clear from the records how the wound developed but I believe it was related to her previous complaint, on 30 May 2022, that she had ulcers on her right ankle during her last EPUT admission an in-patient. There is no evidence that she received any medical attention in response to that complaint. I find it very troubling when staff knew that she had a history of NMS and she was on Clozapine at this time, a strong anti-psychotic medication, which I would expect Sophie to be closely monitored on. Particularly given the other physical side effects Sophie had reported at the time – like uncontrollable dribbling and numbness. I'm aware of studies that Clozapine can trigger skin reactions which can sometimes manifest as sores or ulcers and skin-picking behaviour[1]. It makes me angry even contemplating that Sophie's ankle was left to deteriorate to a point where it required surgery, particularly when the records suggest she was so distressed by this that she was sedated.

106. I have a recollection that there may be a reference in Sophie's records to it being caused by a fall but I struggle to accept that explanation based on how the wound was described and reading that she had reported ulcers on her ankle a month prior to that, and was probably picking at it. She'd been observed 25 June 2022 by the Home Treatment Team to have been scratching her skin, which she had reported was to dig out bugs.

Basildon General Hospital, Katherine Monk A Ward

107. After Sophie's surgery it is noted in Sophie's records that she was paranoid that the government were tracking her through items which had been surgically implanted during her ankle surgery.

[1] https://gpsych.bmj.com/content/31/2/e000012

108. Sophie was transferred to Katherine Monk A Ward at around 7pm on 1 July 2022. This is an acute general-surgery ward of Basildon General Hospital and where Sophie's ankle was further treated. It falls under Mid and South Essex NHS, rather than the Basildon Mental Health Assessment Unit, which is under EPUT.

109. Later that evening, Sophie absconded from the general ward , walking towards a motorway. The police were apparently called. The records suggest that Sophie continued to be really upset about the surgery. She was observed by staff to say, "*the Government has put something in my wound and they are telling me to kill myself*." Sophie responded to verbal de-escalation and she returned to the ward. A Datix Incident Report was raised but there is no mention of it being an absconding incident.

110. On 2 July 2022, the progress notes repeatedly mention Sophie talking about her belief that the government and/or her doctors had put a chip in her – particularly inside her wound – listening to her thoughts, and telling her things. She also expressed suicidal ideation and said that she wanted to die.

111. Sophie continued to express these sentiments the following day on 3 July, but also began saying that she did not wish to take her anti-psychotic medication as the government would do something to her if she did.

112. On 4 July, Sophie appears to have refused to take the antibiotics for her ankle, and she repeated her belief that the government had placed something inside her ankle. It is not clear from the records whether she was willing to take her other medication including her anti-psychotic medication.

113. On 6 July 2022, Sophie refused to comply with her anti-psychotic or antibiotic medication. She was told she was medically fit for discharge from the general ward and told she would be transferred back to the Mental Health Assessment Unit.

114. Sophie then absconded from the general ward again and walked to the main roundabout next to the hospital. The police were called by support workers but could not attend. Sophie threw her phone and said that she wanted to jump into the main road, but did not want to do so in front of the two staff members present. She removed the bandage from her ankle and said that she hoped she would get sepsis and die. She

repeatedly said that she did not want certain staff members to hold her down and give her injections because she knew them well and it would break trust. Staff remained with her for almost two hours, at which point a qualified nurse came to speak to Sophie and persuaded her to go to the Mental Health Assessment Unit. This absconding incident was not recorded in a Datix Incident Report.

Basildon Mental Health Assessment Unit

115. On return to the unit, Sophie said that she did not want to be back but could not be bothered to talk about it.

116. Over the next few days, Sophie appears to have had mixed compliance with medications – mainly refusing to take her antibiotics. Some records, including for 10, 11, 12, and 13 July 2022, state only that Sophie *"complied with some of her medication and declined others"* but do not provide further detail of which medications she was taking or not. This strikes me as unsafe – Sophie was on so many medications, as I discuss below, and I am frustrated that there is not an accurate record of what medications she was taking and I see it as a further example of how careless staff were at monitoring her medication.

117. On 10 July 2022 Sophie was restrained and taken back to her room following an altercation between her and another patient. Although Sophie was still being nursed on Level 3 observations, on 12 July no observation records were completed between 11:00 and 13:00. The observation entry for 14:00 that day states that Sophie was observed to be crying, but said that she did not want to talk about what was wrong. Subsequent entries the same day record Sophie going into her room because of an incident involving another patient, and remaining in her room until that incident was settled. The nature of the incident is not described, but records for later the same day note that Sophie was shouting at staff, agitated, paranoid and in a low mood.

Transfer to Willow Ward

118. On 14 July 2022, Sophie was transferred to Willow Ward at Rochford Hospital. It was only after Sophie's death that I learnt about this ward, and the appalling conditions and practices on it. Willow Ward was not safe for Sophie, and perhaps not for any patient. I

believe the environment, and practices of staff on the ward, further contributed to her risk.

119. As part of preparation for Sophie's inquest, my lawyers obtained a copy of the CQC's inspection report for EPUT services, which identified multiple issues on Willow Ward between November 2022 and January 2023, including[2]:

A. Failures by staff to follow policies and procedures
B. Very high levels of vacancies and sickness among staff meaning there were not enough nursing and support staff to keep patients safe;
C. The second highest use of unqualified temporary staff across the EPUT estate;
D. Low staff compliance with mandatory training;
E. Evidence that staff were not completing or updating risk assessments, were not aware of patient risks, and were not always able to identify or respond to changes in risk;
F. High levels of restrictive practice including the highest level of restraints across the EPUT estate;
G. Failures to obtain patient consent to the use of the Oxevision system in patient bedrooms;
H. Lack of any psychology staff on Willow Ward, and no plans to recruit[3].

120. Although the CQC inspections appear to have taken place after Sophie died, many of the findings seemed to hold true for Sophie's time on the ward from the records I have seen. For example, I have not seen any indication in Sophie's records that she ever had access to a psychologist, or psychology support on Willow Ward suggesting that such support may not have been available to any patients.

121. Whilst Sophie was seen by an Occupational Therapist, **[I/S]** on 22 July 2022 this appears to have been for practical support tasks. For example, on this occasion Sophie was invited to attend a "*basic food based task assessment session*" to make a banana split, which Sophie declined to attend. Sophie was then invited again to attend a task specific food preparation session on 26 July 2022, which she declined.

[2] CQC inspection report available: https://www.cqc.org.uk/provider/R1L/inspection-summary#Acute-wards-for-adults-of-working-age-and-psychiatric-intensive-care-units
[3] CQC inspection report, pg 115

122. Within its findings the CQC stated: "*The trust must ensure sufficient numbers of suitably qualified psychology staff deliver care at Willows and Cedar ward. (Regulation 18. (1))*[4]" I understand from my solicitor that this is a reference to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to providers deploying enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements.

123. Multiple witnesses at Sophie's inquest referred to the ward having *"high acuity"* levels, which was explained to mean that there were a lot of very unwell patients on the ward. I would like it to be noted that Willow Ward is an Adult Acute Mental Health Ward. It should surely be a starting point that those requiring admission to such acute wards are likely to be very unwell. Throughout Sophie's inquest, I got the sense that in reality "high acuity" was being used as a loose cover for an unsettled environment with high levels of restraint.

124. The ward manager, **[I/S]** acknowledged in Sophie's inquest that there may be a link between the high levels of restraint on the ward, and the high levels of bank and agency rather than permanent staff on the ward. Staff including Health Care Assistant **A**, Nurse **A** and Nurse **B**, all accepted that they had less time for therapeutic engagement with patients as a result.

125 **HCA A**, giving evidence at Sophie's inquest, said that when an incident was happening on the ward Sophie would take herself to her bedroom to stay out of the way. The picture of Willow Ward that emerges is not of a therapeutic environment but of a chaotic, and dangerous space, where there was no therapeutic support for Sophie. Engagement with the therapy team had also been removed from her care plan when it was updated on 27 June 2022 and she was re-admitted to Basildon Mental Health Assessment Unit which seems to exemplify clear deprioritising of therapeutic support in Sophie's treatment. It leaves me thinking about how distressing it must have been for her to be on a ward where so many of the staff may not know the patients, restraints were happening frequently, alarms sounding constantly and no psychological support.

126. On transfer, it was noted that Sophie had a diagnosis of schizoaffective disorder, OCD and PTSD, and that she was:

[4] Ibid, pg 9

a. On level 3 nursing observations
b. Not fully compliant with medications (refusing antibiotics and antipsychotic medications)
c. Initially irritable on admission however has settled
d. Adequate sleep and dietary intake
e. No evidence of low mood and related biological depressive features
f. No evidence of psychosis – responding to hallucinatory stimuli and expressing paranoid like ideation.

127. It was also noted that information passed on from Southampton Crisis Team had included that Sophie had a diagnosis of EUPD, used self-harm as a coping mechanism, and used daily ligature attempts.

128. Sophie's risk assessment states: *"continues to express ongoing suicidal thoughts and historical risk of attempting to ligature, reported multiple past suicide attempts including overdose and hanging"* and a provisional diagnosis was made of relapse of schizoaffective disorder in the context of non-compliance. Sophie was assessed as high risk of suicide, disengagement with treatment, and accidental self-harm with specific reference to the risk of impulsive behaviour and misadventure due to commanding voices, as well as medium risk of deliberate self-harm. Sophie's identified risks were recorded as: suicidal ideation, risk of ligature, hearing distressing voices asking her to end her life and that of others, non-compliance with prescribed medication and treatment, poor insight into her mental health, poor sleep, irritability, and risk of infection in her surgery site. The plan recorded was to continue with Sophie's assessment and present medications and to review her on *"Monday next week to commence treatment"*.

129. Despite identifying all of these risks, it appears from the records that very shortly after Sophie's admission, staff began to disbelieve, or express scepticism, about the severity of her condition.

130. Sophie's Responsible Clinician, Dr C , described his first contact with Sophie as having been on 15 July in his witness statement to Sophie's inquest. However, Sophie's medical records stated that she was reviewed by Dr C along with a support worker on the evening of 14 July. Dr C sought to examine her ankle, but this was refused by Sophie. Sophie was questioned about why she had refused to take her antibiotics and reportedly presented as angry and said: *"it's a long story, I don't want to*

talk about it, and this hospital does not know anything which is why I want to leave." Dr **C** terminated the review because, in his words, Sophie became distressed and agitated.

131. This appears to have set the tone for Sophie's relationship with Dr **C**. As I discuss further below, there appears to have been a poor relationship, lacking trust in both directions, and it does **not seem to have been therapeutic.**

132. In contrast to Dr **A**, Dr **C** said in his evidence at Sophie's inquest that when she was transferred, he had only *"very scanty notes"* without much detail. He requested further notes from her GP, the Trust in Southampton, and her care co-ordinator but these arrived in a piecemeal way. He said *"it was a little bit difficult to get notes from Southampton"*, and that most of these arrived after Sophie had already passed away. Despite that, he considered that he did have sufficient information to diagnose and treat Sophie, but that her past records would have given *"a better roadmap"* for her future care plan. I do not accept that Dr **C** had a lack of information available to him to understand Sophie's risk. This is apparent in contemporaneous notes created by EPUT which reflected Sophie's long and prolific history of inpatient care, impulsive self-harm, suicidal thoughts, auditory hallucinations, paranoia and delusional belief. Sophie had also been detained in EPUT's Basildon Mental Health Unit for around seven seeks between April and May 2022. This afforded EPUT a direct opportunity to learn about Sophie, monitor her mood, behaviour, mental health, associated patterns and triggers and therefore risk management.

133. During the ward round on 15 July 2022, Sophie reported that she had stopped taking her medication because the government had been putting parasites in her blood, that she did not believe there was anything wrong with her, and that she wanted to go home. She was told that she would need to have injections if she did not accept anti-psychotic treatment. A nurse on the ward, **Nurse A**, observed that Sophie's behaviour was *"bizarre – there was no eye contact – she was clicking her fingers. She was encouraged to appeal her section. Her presentation did not show true signs of psychosis – it was discussed after the meeting that there could be an element of behaviour and manipulation involved."* I am concerned that this scepticism and disbelief of Sophie had a negative impact on the care she received from staff.

134. Between 15 and 16 July, Sophie's observation records include references to her being restless and anxious, pacing, headbanging, and tapping her fingers, and not interacting with peers or staff.

135. On 17 July 2022, Sophie told staff that she did not want to be in hospital or take medication. She said that she did not believe a life within mental health services was a *"true life"* and that she believed that the government was talking to her through her body. She expressed negative feelings towards men, saying they had *"done enough to her in life"* and that they continued to try to control her. She declined her medication.

136. On 18 July 2022, Sophie attended a ward review with her Consultant Psychiatrist, Dr **C** Her records indicate that before the review she was seen smiling and engaging, but her presentation shifted when she entered the ward review. Nurse **B** **[I/S]** who was also present at the ward review, describes that Sophie looked at the floor, clicked her fingers, and appeared to be responding to unseen stimuli. Sophie told the ward review that she did not want to be in *"this government facility anymore"*, that she was still hearing voices she believed to be the government telling her to hurt people, and that she wanted to go home. **Nurse B** writes that Sophie was *"adamant"* that she did not want to take her medications, in response to which Dr **C** told her he would prescribe an injection if she refused to comply with oral medication. At the ward review, Sophie was assessed as at moderate risk to herself.

137. Later that day, observation records for 18:00 to 19:30 state that Sophie was observed head banging on the wall of the washroom. The observation records for 19:00 to 21:00 appear to have been combined, and state that Sophie entered her bedroom *"lay on the bed, stood up and went to use the toilet at some time change her cloth and used her* **clothing** *to ligature"*. The record states: *"Alert was raised and support was given by cutting off the ligature"*. I understand this was an alert from the Oxevision system installed in Sophie's bedroom. It appears from this record that Sophie ligatured in her bathroom and this was confirmed in the Trust's post-death investigation report. However, this is inconsistent with case progress notes which record that Sophie ligatured in her bed after pulling her bedding over her head. It is very concerning to me that Sophie's records are not even clear about where really significant and potentially life-threatening incidents have taken place.

138. I know that the remote vision-based monitoring system Oxevision was used on Willow Ward, including in Sophie's room. I also know that on EPUT wards the system sends

an alert to staff when a patient has been in the bathroom for 3 minutes. It is not clear from the entry on the observation records whether staff were alerted to Sophie's ligature by an alert from the Oxevision system. Sophie was on Level 3 1:1 observations, meaning she was meant to be in a staff member's line of vision at all times. She should not have been able to ligature, and it should not have required an Oxevision alert to make staff aware of her ligaturing.

139. The name of the staff member conducting Sophie's observations is not clear from the observation record, however, I note that the observation record refers to the gender of the observer as male. This concerns me for two reasons. Firstly, Sophie had been expressing distrust of men only the day before. As a survivor of sexual violence, I wonder whether Sophie may have particularly struggled to trust, or be cared for by, male staff. It is hard for me to know whether this was the case or not. It appears from her records that Sophie's relationship with her male Consultant Psychiatrist, Dr C was particularly fraught, but the issue never seems to have been explored with Sophie by staff. Secondly, the Patient Safety Incident Investigation (PSII) report undertaken after Sophie's death states that the male member of staff observing Sophie did not accompany her when she went to the bathroom. I am concerned that a male member of staff may not have felt comfortable observing Sophie properly when she entered the bathroom, and this may be why she was able to ligature, and an alert was required to bring it to staff's attention.

140. Following the ligature attempt, Sophie was warned that if she declined her medication, it would be administered by depot. Sophie told staff that the reason for her ligature attempt was the fact that she did not want any *"government medication"* and did not want to be injected. The plan in response was to remove all contraband, continue on level 3 observations, and inform the doctor of any concerns. It does not appear that any consideration was given to building trust with Sophie, or de-escalating her paranoia about the new ward and the medication.

141. Sophie's risk assessment was updated to include reference to the ligature attempted on 18 July 2022 and continued to refer to Sophie as at high risk of suicide and accidental self-harm. The risk assessment did not include references to the 4 ligature attempts Sophie had made as an inpatient throughout May 2022, or at home on 23 June 2022. The risk assessment also did not include reference to the fact that again, shortly before a ligature, Sophie was observed head banging. I believe this was an important warning behaviour from Sophie, that she was not coping well, and a clear indicator of escalation

in her risk, that had now happened twice on EPUT wards, but was not being picked up as a pattern. As I discuss below, this is significant because Sophie was seen by staff head banging very shortly before she fatally ligatured.

142. On the morning of 19 July, Sophie's records suggest that she was seen engaging with others in the garden in the morning before she was called in for a ward review with Dr C once again. Nurse B notes that, when Sophie entered the room for the ward review, Sophie *"put her head down and started clicking her fingers"*, and started responding to unseen stimuli. Sophie told the ward review that she wanted to go home and die. She spoke again about believing the ward was a government facility and that if she took medication, the government would rape her sisters.

143. Dr C told Sophie he believed that she knew she was in hospital and asked her why her presentation had been settled at Basildon, but was different here. This is another example of disbelief by staff in the severity of Sophie's condition. There does not appear to be any relationship of trust between Dr C and Sophie in either direction, and I do not see how this could have been conducive to a therapeutic relationship. I am also frustrated that Dr C did not appear to have been aware of, or otherwise acknowledged, Sophie's deterioration during her time on Katherine Monk Ward, which included two attempts to run into traffic and refusal to comply with her medication.

144. In response to Dr C s questioning, Sophie appears to have become frustrated, and raised her voice. Dr C 's response was to ask her why she had not appealed her section. Sophie replied that she believed if she appealed, her sisters would be raped. Once again, she was adamant she would not take oral medication, or agree to a depot injection. She left the room. The ward review record includes an incomplete capacity assessment for Sophie.

145. After leaving the ward review, Sophie asked for assistance in appealing her section and was signposted to solicitors. Her observation records reflect that Sophie was upset following the ward review, and attributed that distress to the ward review. She continued to decline her medication.

146. In the early hours of 20 July 2022, after self-harming by picking at the wound on her ankle, Sophie told staff again that she was upset with the ward review and that Dr C did not understand her.

147. Sophie was reviewed again by Dr C that day to discuss her refusal to take medication. Sophie stated again that she just wanted to go home and did not want to take her medication. Dr C told her that they would try to obtain her notes from Southampton. Again, the ward review record includes an incomplete capacity assessment.

148. On 21 July 2022, Sophie would not consent to a depot injection of Clopixol. She told staff that she did not want the injections because she believed it was a ploy by the government to insert parasites into her body, which she would later need to scratch out from her skin. She was restrained in order for the injection to be administered.

149. Sophie continued to decline some of her medication on 22 July, and appears to have spent most of the day in her bed area, only entering the garden in order to vape, and declining her dinner. Her presentation is described as lethargic and sleepy, and this was attributed by Nurse A to the injection she had received the preceding day. Occupational Therapist [I/S] visited Sophie and tried to engage her in a food making exercise, which Sophie declined. The OT noted that Sophie's room was untidy and chaotic. Staff reported that Sophie had been addressing personal hygiene only sporadically. Self-neglect was a known early warning of a deterioration in Sophie's condition, noted in earlier care plans.

150. A ward review took place on 22 July, once again, it was noted that Sophie would continue to receive depot injections of Clopixol because she was not taking her oral medications. Sophie does not appear to have engaged in this ward review, and she is described as both *"well-orientated"* and *"disconcerted"*. Her risk to self was assessed as moderate. Dr C said in his oral evidence to Sophie's inquest that he held that review to check if she was experiencing any side effects from the injections. He said that these side effects included drowsiness and fatigue, as well as stiffness, slow movement, and tremors. Nursing staff had clearly identified that Sophie was experiencing fatigue as a likely side effect of the depot injection. Despite this, Dr C's took the view that Sophie had not experienced any side effects and was therefore content for her to continue to receive them. He noted that her demeanour in that ward review was far less hostile, and *"much calmer"* than in previous interactions he had with Sophie. Looking at the records as a whole, I wonder whether this apparent increased calmness was in fact Sophie's general fatigue and lethargy following the injection.

151. On 23 July 2022, it is recorded that Sophie complied with some of her medication, but not all of it. Nurse B noted that she presented as *"very quiet in mood and has*

engaged superficially with staff when she has a need to be met. She has engaged minimally with other patients".

152. Sophie declined at least some of her medication on 24 July but was noted to have complied with her night medication at least on 25 July 2022.

153. On 26 July, when Sophie went for her medication, she told Nurse **B** that she would only agree to take one of her tablets, because *"if I take all of my medications I want to kill myself but I can't because I am on level 3"*. She also said that she had taken her clopixol for the last 3 nights but that now *"the government are really pissed off with me"* and were *"sending me messages through the air conditioning"*. She also said she felt suicidal after taking her medication, and that she believed her family would be hurt if she took her medication.

154. The records suggest that during a ward review, Dr **C** discontinued the majority of Sophie's medication, but she had agreed to take Lamotrigine and Thyroxine. She was maintained on level 3 observations by Dr **C** *"due to her diagnosis of EUPD and her impulsive behaviour"*. Sophie's presentation in the ward review was irritable.

155. Once again, after the ward review, Sophie's presentation was described in her records as *"agitated"* and she was noted to have gone around communal areas knocking on doors and walls.

156. There are records for 26 July 2022 referring to Sophie's property being returned to her following its removal after an incident on the previous shift. It is not clear from the records what the items of property were, or what the incident on the previous shift was. I still don't know whether this is suggesting that Sophie's property, which was removed following her ligature attempt on 18 July, was returned to her or not. At Sophie's inquest, Health Care Assistant **A** was asked about this and said that she believed the property in question was confiscated from her following a ligature incident, but she was not sure which incident. This was apparently authorised by the nurse in charge because Sophie had not had any incidents for at least 48 hours. She said that the items returned included **clothing**. Presumably, this included the **item** that Sophie would ultimately use to fatally ligature. There is no risk assessment of this decision in Sophie's medical records. Dr **C** agreed in his oral evidence to Sophie's inquest that this should have been recorded in the nursing notes. Nurse **B** stated in her evidence that they would have completed a property sheet when returning property to a patient, but no

such document has ever been found. She also stated that it would have been good practice to formally record a risk assessment before doing so.

157. On 27 July 2022, Sophie once again would not accept the depot injection and her oral medications, saying that she would not take any medication from the government. She was restrained by the rapid team, and the medication was administered forcibly.

158. On 28 July 2022, [I/S] the Occupational Therapist, noted that Sophie had consistently refused to engage with them, and had been observed to spend most of her day in her room, sleeping, not changing clothes from her sleep wear, and with her room disorganised. When she did engage with the occupational therapy team, she would limit the duration of the conversation and provide monosyllabic responses. This lack of engagement was of sufficient concern that it was noted it would be discussed in an upcoming MDT meeting on 1 August 2022. As I have mentioned above, social withdrawal, and self-neglect had both been identified as early warning indicators for Sophie, and it is plain that on Willow Ward, both of these were worsening. By 28 July, Sophie has gone from changing her clothes periodically, to apparently not changing them at all. Her risk assessment does not appear to have been updated to reflect this. Although the OT records that she completed an activity programme for Sophie, it is not clear whether this was written with Sophie's involvement, or what was included in that programme.

159. On Friday 29 July 2022, Sophie was seen again by Dr C and reported that she still felt suicidal and believed the government was persecuting her. Sophie was asked what she would do if she as on level 2 observations and experiencing suicidal thoughts. She was not able to answer that question. Her observations were maintained as Level 3 because of her discussion of suicide.

160. On both 28 and 29 July, Sophie was noted to have complied with her prescribed medications, but the exact medications she was given are not specified in the records.

161. On 30 July 2022, Sophie's records describe that she complied with her medication, was settled, but was not interacting with staff or peers unless she needed something. Her initial assessment of needs and risk appears to have been updated the same day, but the risks appear broadly the same, and she is still assessed as at high risk of suicide and accidental self-harm and medium risk of deliberate self-harm. A capacity assessment is included in the documentation which states that Sophie has capacity to

understand information regarding being an informal patient. Sophie was not an informal patient, she was detained under section. I find it very frustrating that, once again, the records are inaccurate. It reflects the total lack of appropriate care and attention given to Sophie, her care needs and risk.

162. On 1 August 2022, Sophie declined to have her vitals taken and did not go for her medication. A ward review is said to have taken place on 1 August following which observations were lowered to enhanced Level 2, meaning she would be checked a minimum of 6 times per hour. Her care plan recorded the following: *"I do think about hurting myself sometimes but I agreed with the doctor that I would be seeking help from staff if I struggle. I was put on enhanced level 2 observations. I was explained that I would be checked on minimum 6 times per hour"*. Her initial assessment of needs and risk was updated to note that the observation level had been reduced – though the assessed risks themselves were not changed. I have not seen a record of a ward review or MDT on 1 August.

163. There is a note on the same day that Sophie mentioned being fatigued after receiving an injection. It is not clear if that injection was administered that day, or whether Sophie was restrained for that injection to be administered. I have not seen any record of Sophie being administered an injection on 1 August.

164. The following day, on 2 August 2022, at another ward review, Dr C asked Sophie about her finger clicking, which was something she had been observed doing at most of her ward reviews. Sophie told him that it helped her block out what the government was saying. She said that she did not want to register with a GP because she did not want the government to have access to her records. She stated that she did not want to take the depot injections because the government was not happy with this, and that she did not want to take her Lamotrigine either. She asked to be discharged, and said her family was in danger the longer she stayed in hospital and had injections. She asked for a break from depot because it was *"barbaric"* and then appears to have stormed out of the ward round. Other notes of the meting suggest that Sophie told Dr C he had the power to discharge her and said *"I don't want to kill myself anymore"*.

165. On 3 August 2022, Sophie first refused, but then accepted her depot injection. Throughout the morning she seems to have remained in her bed area, and declined meals. However, in the afternoon, observation records suggest that she took a shower, applied perfume, ate dinner, and spent some time in the communal lounge area

"engaging with peers". She attended book club and engaged with Occupational Therapy team.

166. On 4 August 2022, Sophie was allowed escorted section 17 leave for 30 minutes twice daily within the hospital grounds. She took leave at 18:00, returning at 18:15. The inpatient leave risk assessment which is marked *"to be completed prior to any period of leave"*, has not been filled out.

167. On 5 August 2022 Sophie approached two members of staff and told them that her family would be hurt because she had the depot on Wednesday willingly. She reported that the government told her this and she wanted to have a break from the oral medication and depot. However, a continuation sheet of the same day states that Sophie was compliant with and accepted her medication.

168. On the same day, Sophie's leave was suspended after she left the hospital grounds in breach of the terms of her leave. She told staff on her return to the ward that she had wanted to jump in front of traffic.

169. At her inquest, ward staff attempted to downplay the seriousness of this incident. Dr C said in his evidence that it was *"not an incident per se"* and said that he would not consider that the incident was due to mental illness or psychosis. When challenged on this, he said that he was not aware that Sophie had reported that the government had told her to go into traffic, but maintained despite that that the incident would not necessarily signal an increased risk profile.

170. In the afternoon of 6 August 2022, there is a record from Nurse B noting that Sophie approached staff and asked to talk to them. She reported that every Friday she received new information from the government, and said that *"yesterday they infiltrated my sisters school and sat outside my families [sic] house"*. When asked about her leave earlier in the day, Sophie said that she had been told by the government to run in front of traffic. She said to Nurse B *"I know you are a nurse and that Dr C is a doctor but my thoughts are getting scrambled."* Nurse B advised Sophie to write her thoughts down and discuss them with Dr C.

171. To me, this represented Sophie being very open with a member of staff about the fact that she found Fridays particularly difficult – that they were a particular peak in terms of her auditory hallucinations. This is obviously really important information – several of

Sophie's recent ligatures had taken place either on Friday, or around Fridays (Saturday 7 May, Thursday 12 May, Friday 27 May, Thursday 23 June, Saturday 25 June), and she would ultimately fatally ligature on a Friday two weeks from making this disclosure to staff.

172. Nurse B did not make a record in Sophie's care plan or risk assessments of this disclosure from Sophie about her patterns of risk. At Sophie's inquest, Nurse B said that she could not recall why she did not update the care plan with that information.

173. On the evening of 6 August, shortly before 7pm, after some time in the garden, Sophie is noted to have barricaded the front door, pushed staff away and begun shouting, saying that people would hurt her family. At around 19:30, an entry in the observation records notes that the Rapid Team were contacted and Sophie was placed in an *"arm hold and away from the door. At end she was restrained"*. Entries for 19:41 appear to suggest that Sophie was restrained again once in the corridor.

174. On 7 August 2022, Sophie declined her medication again.

175. On 9 August 2022, Sophie had another ward review meeting. Before she joined, clinicians discussed Sophie's lack of compliance with medication, and it was noted that they did not understand all of her prescribed medications, so there was a need to obtain further historical records from Southampton.

176. When Sophie joined, she told clinicians that the government were sending messages to her sisters because she had accepted the depot injection, that she believed Dr C had asked nursing staff not to switch off the lights to make it uncomfortable for her, and that the parasites from the depot were causing her a headache. Reading these records, it appears to me that Sophie's relationship with Dr C had deteriorated further by that point – he was now one of the objects of her paranoia. I do not know what lights Sophie is referring to but having since seen photographs of the Oxevision system I'm upset at the thought of it being a possible reference to the lights from the Oxevision system that would have been in her room.

177. Sophie asked about leave, and Dr C told her that she could have leave after she took the injection and was more settled. Records note that Sophie avoided eye contact, and reacted with anger when her statements were challenged by clinicians who questioned why the government did not want her to take her medication, or why she listened to the

government to prevent her family from being hurt. I was not present in the ward review, but reading through these records, it appears staff adopted a very confrontational and adversarial manner towards Sophie. When I think about Sophie's experience at that ward review, I cannot help but feel that she might have experienced that approach as having clinicians gang up on her. I do not understand how that approach could be therapeutic, and she obviously found it distressing as she is noted to have become increasingly agitated throughout the meeting. I do not understand how that approach could assist in building a trusting relationship, particularly where Sophie had already expressed such deep distrust, and feeling of being misunderstood.

178. The records of the ward review outline that her risk to herself was considered moderate after the ward review, and that it was considered that she had capacity to consent to admission – which contradicted that she had not consented to the admission and had been detained under section and had repeatedly asked to leave the ward since – but that she did not have capacity to consent to treatment. There is no paperwork, or more expansive record or discussion of how her capacity was assessed, or how these conclusions were reached.

179. Staff appear, again, to have been sceptical of Sophie's presentation. The record made by **the CC** states *"[i]t was summarised that the psychotic part of the case was not that sure, not clear and not that obvious"*. Despite this, it was agreed that Sophie's antipsychotic treatment would be increased. If staff really believed Sophie may not be psychotic, it troubles me that they would be willing to increase her medication in spite of that. I discuss this further below at [278 -286]

180. Sophie's depot injection was due the same day. She declined it, and at least some of her prescribed medications. She also declined to complete GP registration forms.

181. On 10 August, she refused some of her medication, and accepted others. On 11 August it is said that she accepted at least some of her medication – Lorazepam and promethazine in the evening.

Final week of Sophie's life

182. On 12 August, it was noted that Sophie was still refusing the depot injection. She was told that staff would administer it against her will, and a restraint team was put together. An altercation appears to have followed where Sophie grabbed the needle, and

dragged it on the floor, damaging it. Sophie eventually agreed to have the depot injection without restraint. She also accepted her prescribed medication that morning, but refused it in the evening.

183. When questioned about this incident at Sophie's inquest, Dr C said again that he did not consider that Sophie's behaviour was due to her mental illness or psychosis, but instead it was just a *"patient resisting treatment"*. This completely ignored that Sophie's resistance to her medication was frequently and repeatedly expressed to be linked to her paranoid ideation about its content, and her auditory hallucinations of threats from the government linked to her taking her medication.

184. Dr C also maintained at Sophie's inquest that she was *"concordant"* with medication. This shocked me. My lawyer challenged him on this and pointed out that she was refusing oral medication, had to be restrained, or threatened with restraint, before medication could be administered. Dr C referred to this as *"semantics"* and said that her *"compliance was fully maintained"*. I think this was appallingly disingenuous. There is a huge difference between complying with medication, and being forced or coerced to take medication – not least the implications for how well a person will continue to comply when off the ward and no longer subject to those coercive measures.

185. Records for 13 and 14 August indicate that Sophie was complaint with her prescribed medication.

186. However, at Sophie's ward review on 15 August 2022, it was noted that Sophie had *"been refusing all oral medications aside from chlomipramine [sic] and mirtazapine"*. Once again, this careless inconsistency is unacceptable because it meant that it was fundamentally unclear what medications Sophie was or was not taking and so there is no way that her medication was being appropriately monitored

187. At the same ward review, Sophie apologised to Dr C for breaking the needle when her last Clopixol depot was administered. She stated that she wanted to show that she was working with him, and that she had accepted the depot two weeks in a row without any incidents requiring restraint. This is not true given that her most recent depot, only 3 days earlier, was only administered after an altercation and a threat of restraint, and she had been restrained twice by staff less than a fortnight ago on 6 August.

188. Sophie continued to have thoughts about the government conspiring against her, and to voice her desire to appeal against her detention, go home and be left alone.

189. Dr C told Sophie that her Clopixol depot dose would be increased from 400mg to 600mg from 18 August. He asked her about her "*physical health medications*", which she said she did not care about, and did not need.

190. Sophie was granted escorted leave for 20 minutes twice a day until 20 August 2022, which would be within and outside of hospital shops, and at the discretion of staff.

191. Shortly after the ward round, Nurse A noted that Sophie presented as angry and impatient, still sharing concerns that the government was after her. Less than hour after the ward review, a Datix Incident report was logged for an altercation between two service users. The names of the service users are not specified but because there is a subsequent note in her medical records of Sophie hitting a peer, I can only assume that it relates to her.

192. It seems to me that there was a pattern of Sophie becoming increasingly agitated and distressed following ward reviews. This does not appear to have been identified by staff, or reflected explicitly in Sophie's records.

193. The Datix Incident form for the altercation is timed 15:55. At 16:32, despite less than an hour elapsing since she had been involved in an altercation with another service user, Sophie was granted escorted leave. I have not seen any risk assessment for that leave, or relevant leave form.

194. The same day, the CC contacted Dr C and advised that she had received and reviewed Sophie's notes from Southampton, and that it appeared Sophie had been in and out of hospital for longer than they had previously realised. She provided Dr C with the details of the previous admissions, and noted that Sophie had historically disengaged from services when she was discharged from hospital in Southampton.

195. On 16 August 2022, an MDT discussion took place including Dr C and Nurse A and Sophie's observations were reduced to Level 1 – general, hourly checks. The reasons noted by Nurse A on the plan were: *"The patient presents as more settled and is working toward unescorted leave arrangements"*.

196. Sophie's care plan was updated to reflect this, stating that Sophie had been informed that if she felt suicidal or like self-harming, she would be offered a 1:1 discussion and PRN oral medication. It also stated: *"if I refuse oral medication and the nurse in charge is concerned about risk associated with severe agitation then the use of IM medication will be considered… following an incident of violence and aggression I will be offered a de-brief by a qualified member of nursing staff"*.

197. On 17 August, Sophie was observed to have kept a *"low profile"*, spending much of the day in her room unless vaping or attending meals, and to have complied with her medication. She took escorted leave twice at 13:55 and 15:25.

198. On 18 August, Sophie accepted administration of the higher dose depot injection without restraint. Again, she was observed by staff to have slept a lot and mostly isolated herself in her room.

199. Describing the last two weeks of Sophie's life at her inquest, Dr C maintained that Sophie had settled in her behaviour, that her interaction was *"very good"* and that while she did become agitated at ward reviews with him, this was *"understandable"* because he was *"asking her questions she found uncomfortable"*. I do not think this description is particularly consistent with the records I have seen of Sophie's time on the ward. Her engagement and interaction with staff or other patients seems, as far as I have seen, to have been very minimal. As mentioned above, records for both 17 and 18 August note that she was keeping mostly to herself. She had also been involved in an altercation with staff as recently as 6 August and tried to walk in front of traffic.

Day of Sophie's death

200. On Friday 19 August 2022, Sophie attended a ward review where she was informed that her Mental Health Tribunal to appeal her section had been postponed, and expressed her upset at the delay. She said that she would not take her depot injection, and that the government was still after her. She reported a headache and asked for paracetamol. When asked how she would cope if discharged, Sophie reportedly said: *""I will get you into trouble if I tell you. I don't want the government to fuck up my life."* She was told by Dr C that he was considering placing her under a Community Treatment Order and was reportedly also unhappy about that.

201. Sophie was granted unescorted leave at that ward review, for 30 minutes twice daily, both within and outside hospital grounds, at the discretion of staff. Ward manager, [I/S] said in her witness statement that Sophie was pleased to be granted unescorted leave.

202. In his oral evidence to Sophie's inquest, Dr C said that *"on reflection, perhaps one of the reasons I granted Sophie unescorted leave was that the ward was really really unsettled"*. He noted that patients were even having altercations in the garden at the time, and that there were not staff available to take Sophie on escorted ground leave due to *"Willow Ward being what it was, very unstable*". This again, underscores for me how short on staff Willow Ward must have been, and how chaotic the atmosphere must have been for patients like Sophie.

203. At 12:15 and 14:20, Sophie took unescorted leave. The risk assessment form for 12:35 appears to have been completed, but the form for 14:20 does not appear to have been completed. The risk assessment at 12:15 stated that Sophie had not:

a. Engaged in violence and aggression, self-harm or any risk-taking behaviours in the last 24 hours
b. Presented as an immediate risk to others in community
c. Used substances in the last 24 hours
d. Experienced active symptoms such as command hallucinations and paranoid beliefs to harm themselves in last 24 hours
e. Had any physical health issues which might affect leave
f. Expressed suicidal ideation or thoughts of harming others

204. In respect of her second period of leave, HCA C said that Sophie *"was not happy"* when he had to get the nurse to sign off on the paperwork, which took a short time, but that she accepted the reassurance he offered that her 30 minutes would not start until she went out.

205. At around 15:59, Sophie was involved in a physical altercation with another patient on the ward. CCTV footage of Sophie before the incident, played at her inquest, shows Sophie sitting in a communal area, looking agitated, and tapping her leg repeatedly. She had to be physically separated from the other patient, and was then taken aside by ward manager and had a medical check on her toe, having complained that it hurt after

she kicked the other patient. Sophie apparently told **the HCA** that the other patient had been vindictive towards her the other day, and that was why she had kicked her.

206. At some point, later that afternoon, **HCA A** says in her witness statement for Sophie's inquest that Sophie approached her for *"a chat"*. **HCA A** was unable to assist Sophie, however, because an alarm sounded on the ward at that point, and she had to attend to a restraint in another patient's bedroom.

207. In her evidence to Sophie's inquest, **HCA A** explained that that afternoon on Willow Ward was *"particularly unsettled"* with *"numerous"* restraints taking place. She accepted that the high incidence of restraint and incidents on the ward reduced the amount of time staff had to engage therapeutically with patients like Sophie. EPUT insisted at Sophie's inquest that the ward was sufficiently staffed that day, but had to acknowledge that this was only the case because the ward manager, who should have been supernumerary and completing predominantly administrative and managerial tasks, was also acting down as one of the nursing staff on the ward. This seemed deliberately misleading to me – the CQC had clearly identified staffing shortage issues on the ward, and staff at the inquest were accepting in evidence that they felt stretched thin, and that they had less time for therapeutic interventions with patients.

208. CCTV footage shows that at 17:10, Sophie returned to her bedroom. At 17:16, HCA **B** is captured visiting Sophie's room. She reported in her witness statement to Sophie's inquest that this was because she had heard Sophie headbanging, and that on her arrival, she saw that Sophie was in fact headbanging. **HCA B** then went to report this to the Ward Manager, **[I/S]** because she believed Sophie may be upset about the fight with the other patient earlier in the day.

209. At 17:19:11, **ward manager** **HCA B** and Nurse **B** entered Sophie's room. After just 22 seconds, at 17:19:33, Nurse **B** left the room.

210. Nurse **B** said in her witness statement that she and **ward manager** spoke to Sophie and offered her PRN medication, which Sophie declined, asking to be alone. Nurse **B** said that she had no concerns about Sophie at that point.

211 **Ward manager** and **HCA B** remained with Sophie for marginally longer, until 17:21:29 – just over 2 minutes from when they first entered.

212. In that time ward manager said in her witness statement for Sophie's inquest that they observed Sophie headbanging by *"tapping"* her head against the window. At Sophie's inquest, ward manager and Nurse B went further in trying to downplay this headbanging. Nurse B for example, described it as *"light headbanging"* and suggested that Sophie just seemed *"more annoyed than anything"*. She denied that offering Sophie PRN medication represented a recognition that she may be experiencing heightened distress, and said instead that it was *"more that she was annoyed and that might help"*. The WM also described Sophie as *"tapping"* and *"brushing"* her head against the metal mesh covering the window frame.

213. It was put to the WM that this was inconsistent with other evidence – HCA B had said that Sophie's headbanging was sufficiently loud to be heard and identified as headbanging from outside of her room, and the police who attended the scene after Sophie's death had given evidence that they had identified an injury, and blood at Sophie's hairline which was consistent with headbanging. The WM maintained that to her, it looked like Sophie was tapping her head. She also said that the metal mesh was *"soft more than hard"*. I feel that these were attempts by the WM and Nurse B to deliberately downplay the seriousness of Sophie's actions, and the level of her distress, in order to justify their own actions in leaving her alone without support.

214. The WM outlines that Nurse B offered Sophie PRN, which she declined, then left. The WM says that she and HCA B tried to engage with Sophie, but that Sophie was shouting and telling them to fuck off. The WM describes seeing papers on Sophie's bed, which she believed to be solicitor's letters, and seeing that her phone was ringing. She states that she asked Sophie if she wanted her to answer the call, in response to which Sophie screamed that she wanted to be left alone, and then swiped paperwork, but not her laptop or phone, from the table onto the floor.

215. The WM says that she and HCA B stayed with Sophie to give her more time to engage if she wished to do so, but did not try to engage her in conversation as it was clear that she was becoming increasingly irritated. The WM states that she concluded that their presence was making things worse for Sophie so, after making clear that Sophie could have a conversation if she felt like talking, they left. Before leaving the room, The WM asked HCA B to remove a pile of wet towels from Sophie's room.

216. The WM stated that she did not think Sophie's presentation at the time indicated that she was at risk of harming herself. She stated at the inquest that she thought Sophie

had *"had a good day"* and that her actions were *"to show me she wanted some space"*. **The WM** denied that she had the towels removed because they were potential ligature items.

217. When questioned about the brevity of time she had spent with Sophie, **the WM** maintained that it was about the quality rather than length of time spent. She outlined that in her role as a nurse *"sometimes we use talk therapy"* but acknowledged that this was not very effective where Sophie was plainly unwilling to engage. I find it very difficult to accept that there could have been any meaningful attempt to engage with Sophie within 2 minutes. When asked if she had put in place any other safeguards for Sophie, like asking other staff to check on her, **the WM** replied that there was *"no one for me to point out at the time"*.

218. In his evidence to Sophie's inquest, Dr **C** stated that while he was not aware of this episode at the time, he would *"more than likely"* have taken the decision to increase Sophie's level of observations at that time if he had been aware. He explained that he would do so because headbanging could be an attempt to ventilate distress or agitation and she would need to be assessed and the reason discussed with her. He also stated that he would have expected the duty doctor to be notified of the incident, which did not happen.

219. At 17:23:23, Sophie can be seen on the CCTV footage tying a ligature around her neck – less than two minutes from when staff left her alone.

220. The CCTV footage from the corridor captured Sophie's death, and my solicitors prepared a detailed chronology of the timings shown on that footage, in combination with other records disclosed following Sophie's death. I have exhibited a copy of that chronology to my statement, but I will not discuss it here in detail because the content is graphic and highly distressing.

221. At 17:29:40, a bathroom alert was raised on the Oxevision system for Sophie's bedroom because whilst she had a ligature around her neck she had managed to move herself to cross the threshold into her bathroom 3 minutes previously. I understand that this would have meant that the tile for Sophie's room on the Oxevision display in the nursing office and on the handheld tablet, would have turned red, and that an audible alert should have sounded from both saying *"Oxehealth alert"* repeatedly. **The ward manager**

gave evidence to Sophie's inquest that they had two tablets on the ward at the time, but that one did not work.

222. Sophie would have known about this monitoring system, which is set up on all EPUT wards. I have been tormented by thoughts of whether Sophie may have moved into the bathroom space in order to try to trigger the alarm, because she associated it as eliciting a response from staff. As a grieving mother, this is something I have ruminated over, and cannot get out of my head. I think about the fact that barely a month before she died, on 18 July, it appears that she attempted to ligature in a bathroom only for staff to intervene after an alert was sounded. Sophie may not have known how the system worked, she may not have felt safe with the cameras, but I am afraid she might have had a false sense of security in the idea that someone, somehow, would come to help her if she was in the bathroom – she had had a similar experience so recently. Thinking about my daughter alone, dying, while waiting for help that never came is more than I can bear.

223. **The WM** told Sophie's inquest that the Oxevision tablet for the ward should have been with the 'security nurse', **HCA C**. However, he denied having that tablet that day, and said that it had not been allocated to anyone. **The WM** later acknowledged that the allocation sheet for the tablet had not been completed, and said that it may not have been taken *"because of acuity on the ward"* meaning that a staff member may not have been able to hold the tablet.

224. **HCA C** said that *"I was told there was a tablet"* but that he was *"not clear on that"*. He said that staff including himself had not been properly trained in how to use the system. Later in the inquest, EPUT's lawyers tried to suggest that **HCA C** may have been trained without him realising that he was being trained or had been trained. That felt ridiculous to me, especially because my solicitors explained to me that the EPUT's Standard Operating Procedure for the use of Oxevision required staff to have completed a record of competency following their training. This would have presumably made it very obvious that training was being given, and no records of competency for any of the staff on Willow Ward could be found by EPUT when preparing for Sophie's inquest.

225. Nurse **B** gave evidence at Sophie's inquest that it would only be possible to hear the Oxevision alert if you were in the nurse's office at the time. She could not recall whether she was in the nurse's office. She also could not recall whether there was a

tablet on the ward at the time. **The WM** also said that she did not hear the alert sounding.

226. At 17:33, four members of staff can be seen in the corridor by Sophie's room, restraining another patient. HCA **C** decided to check on Sophie *"to see how she was coping with the noise on the ward as it was busy, and because I knew she had mood swings"*. He entered her room at 17:35:39 and found her unconscious. He could not sound his own pin point alarm, and asked another member of staff, **HCA A**, to do so. **HCA A** advised at Sophie's inquest that this may have been because he had not had time to recharge his alarm since the last incident he had been involved in.

227. There were delays in the emergency response which followed, including a delay of some 10 seconds in the rapid alarm sounding, a delay in obtaining the ligature cutter, which should have been immediately available but was not, a delay in beginning compressions, a delay in using the oxygen mask, and a delay in calling an ambulance of some 2 minutes. As discussed further below, both an EPUT internal report, and an A&E expert instructed by the Coroner at Sophie's inquest, described the emergency response as *"confused and disorganised"*.

228. Sophie was ultimately, sadly, declared dead at 18:25.

229. The police attended the ward subsequently, and were advised that there was *"CCTV"* available of Sophie's room. I assume that this was a reference to footage recorded by the Oxevision system. This footage was never provided to the police, and I learnt in the course of Sophie's inquest that it was never retained by the Trust, apparently because the ward manager responsible for requesting that this take place emailed the wrong team with her request, and no one apparently thought to follow it up, or to direct her to the correct team.

After Sophie's death

230. I learnt from Sophie's dad about her death. I know from him that he received a phone call from Willow Ward at around 18:15. It was someone who introduced themselves as a nurse and told him, "*we have lost Sophie*". Sophie's dad was confused and asked her whether they meant she had escaped, when the nurse responded that Sophie had died, he was shocked and told her that he had to hang up to process what she had told him. He then was unable to call back and find out where Sophie was because he had not

taken her name, which added to the confusion and distress. This was a particularly upsetting way to learn of our daughter's death. He had to call Adult Mental Health Services to try to find out which hospital she was at, and had a friend calling Essex Police, who told them that Simon should not have been notified of Sophie's death until uniformed officers visited him.

231. Sophie's dad had a call with Dr C the WM, and Dr [I/S] on 22 August, where he raised a complaint about how inappropriately and insensitively the news of Sophie's death had been delivered. I would learn later that this complaint formed part of the PSII undertaken by EPUT.

232. After Sophie's death, I was left with so many questions about how and why she died in a place where she was meant to be being kept safe. I could not properly grieve, or process her loss without understanding how it had come about.

233. In October 2022, I became aware of the Dispatches programme "Hospital Undercover: Are They Safe?". I now know that the footage of that documentary was filmed between 7 April 2022 and 8 June 2022 – shortly before Sophie was admitted on 14 July 2022. I could not bring myself to watch the documentary but my close friend, who supported me through Sophie's inquest watched it. It was from her that I learnt that it was based on a reporter who had begun work undercover on Willow Ward at Rochford Hospital – where Sophie spent the final weeks of her life, and where she died. I learnt that conditions on the ward were heavily criticised by experts on the programme, particularly in relation to the use of restraint. It was gut-wrenching to learn about this, and I was left feeling very anxious about what Sophie's own experience had been on the ward.

234. After Sophie died, I took over contact with the Coroner's Court from Sophie's dad because he was really struggling. He had been Sophie's Next of Kin but he didn't feel able to engage with services after Sophie died. I think it was within a couple of days of Sophie's death that I tried to get information from the Coroner's Court. I did not know anything about the processes and procedures that would take place. Neither I nor Sophie's dad were given any information, guidance or support from EPUT after Sophie died.

235. At some point I found a suicide bereavement support group, who recommended to me that I should contact the charity, INQUEST. It was only through INQUEST that I learnt

more about the procedures that would then take place and they found me and my family legal representation at the beginning of November 2022.

236. I called EPUT myself a couple of times in the aftermath of Sophie's death because I was trying to trace Sophie's belongings. I do not remember who I spoke with on the first occasion but on the second occasion I spoke with EPUT's Patient Advice and Laison Service ('PALS') and I found them to be abrupt, uncaring and unhelpful when I made enquiries about Sophie's handbag, purse and bank cards. Sophie's mobile had been taken by the police and this was returned to us, but those other items have never been found or handed back to us. Some of Sophie's belongings were later provided to us and they were in a rickety pre-used cardboard box. It painfully symbolised the lack of care to Sophie and her life.

Patient Safety Incident Investigation (PSII)

237. At the first preliminary review hearing for Sophie's inquest, which took place on 4 November 2022, EPUT's lawyers said that a report from their PSII would be provided by 9 January 2023. That was the first time I remember hearing about EPUT conducting any investigation into Sophie's death. I asked Sophie's dad at the time if he had received any information from EPUT about this investigation and he confirmed that he also hadn't been contacted by them.

238. I felt that it was important for me to find out more about this investigation, which I understood was meant to be a process of establishing the truth about the care Sophie received, and for the Trust to learn lessons where things had gone wrong.

239. On 10 January 2023, my lawyers wrote to the Coroner and EPUT as we had not yet received the PSII report. EPUT's response was that the report would now not be provided until spring 2023 because there had been a change in case investigator.

240. My solicitor repeatedly raised with the Trust the need for Sophie's family to be involved in the process, and asked for me to be provided with a copy of the terms of reference for the investigation, and to have an opportunity to meet with the investigator. This did not happen.

241. On 13 April 2023, EPUT contacted my lawyers and said that the draft PSII report was ready to be sent to me for *"factual accuracy checking"* and notified us that the Coroner had extended the deadline for the report to be disclosed until 19 May 2023.

242. My lawyer responded the same day, expressing concern about the lack of proper consultation of Sophie's family in the investigation process – by this point, I still had not received any copy of the terms of reference, for example – and that EPUT *"appears to be seeking to limit the contribution of the bereaved family to a fact checking exercise of the learning response"*.

243. On 18 April 2023, I was contacted by EPUT Family Liaison Officer, **[I/S]** who introduced herself as my point of contact while the Trust's investigation was ongoing. She told me I would receive a draft of the investigation report in a few days, and that if I had any questions, I could pass them to her to go to the investigator.

244. On around 24 April 2023 I received the draft report from EPUT. I had never seen the terms of reference or spoken to the investigator. I was completely unprepared for the information the report contained – no warnings were supplied in advance to tell me that it included a section setting out in graphic detail the CCTV chronology of Sophie applying her ligature, and her last moments as she lay dying. This information came as a total shock to me because no one from EPUT had thought to mention to a bereaved mother that this information had been included in the report. I was really upset when I read that information – no parent should have to lose their child, much less read vivid and traumatic descriptions of their final moments. I was also really angry with EPUT; not bothering to tell me in advance, they took the choice away from me about whether or not I wanted to read that information or not. It felt completely insensitive and inconsiderate, and to me just illustrated how forgotten we as a family actually were in the investigation process – we had been appointed a Family Liaison Officer, but it felt like her job was more to manage us than to actually consider our interests, or advocate for us.

245. More generally, I felt that the report was inadequate, and that there had not been a thorough investigation. Given how long we had waited for it, that was hugely disappointing. I was particularly upset by the lack of any meaningful areas identified for improvement when there seemed to really obvious and urgent issues which needed to be addressed.

246. I met with the investigator in around May 2023 and provided a lot of feedback on the draft report. He initially assured me that a lot of those areas I identified would be changed in the final report. I wrongly felt that I had been heard in that meeting, and I felt reassured that the final report would be better, and that the Trust would address the points I had raised.

247. It took months more for the final report to arrive. On 4 September 2023, I was told by the Trust that they would be sending me the report that week. I asked for a version with tracked changes so I could easily identify what had been changed following my meeting with the investigator. I received no reply.

248. On 5 September 2023 I was emailed the report. I was devastated to find that in spite of the assurances I had been given by the investigator in our meeting in May, there were no substantive amendments to the final reports. I felt ignored, and like I had been treated like a check-box exercise. It underscored even more my feeling that the Trust was committed not to involving families, or engaging with them meaningfully, but to managing them.

249. The report outlined that Willow Ward had reduced permanent staffing levels, btu that it was fully staffed on the day of Sophie's death – though there were only 3 permanent members of staff on the ward. The report noted that Sophie had been in a good mood following her ward review where she was granted leave, but fails to mention the upset she expressed following the same review about her tribunal being postponed. It noted that the emergency response to Sophie's was *"chaotic and disorganised"* and that staff did not feel *"fully able to deal with the event"* notwithstanding that all were apparently up to date with their basic needs training. It identified the following areas for improvement:

a. The introduction of a mobile phone on the ward to be used in emergencies – which was noted to be a pre-existing safety action from a previous report;
b. Avoidance of discharges involving services from different geographical areas, even if the result is a delayed discharge;
c. Adoption of flow chart / algorithm throughout EPUT of process following traumatic incident / death on inpatient wards;
d. Mandating immediate debrief on wards after resuscitation attempts;
e. Introduction of more regular scenario-based training on inpatient wards, specifically in the management of cardiac arrest.

250. Almost all of the "learning" EPUT had identified dealt solely with procedures for after something has already gone wrong. I do not believe that they properly investigated or engaged with issues including:

a. Sophie's discharge from Basildon – this was not just problematic because she of the geographic complications, it also appears unclear to me from the records that Sophie had actually improved sufficiently to be safe when discharged, and the general discharge planning appears to have been poor, and largely reliant on Sophie to safeguard herself.
b. Sophie's safety and treatment on Willow Ward – the frequency of restraints, impact of low staffing on the ward, Sophie's apparently entirely untherapeutic relationship with Dr C, the decisions to lower her observations, and to leave her unattended when she was in evident distress.
c. Sophie's medication – the fact that her records are frequently unclear about what medications she was taking, the effects that the medication was having on her, and the volume of medication she was prescribed.

Essex County Council Safeguarding Report

251. Essex County Council also conducted an Adult Safeguarding Enquiry in relation to Sophie's death. The Safeguarding Concern appears to have been raised on around 22 August 2022 by paramedics from the ambulance service. I am aware that ECC spoke to Sophie's dad about the investigation, and on 26 August 2022, he confirmed that he wanted a full investigation to take place.

252. The investigation concluded on 22 May 2023 that *"there is some evidence that has been provided by EPUT that identifies that Sophie was subject to neglect by EPUT as Sophie was detained under a Section 3 of the Mental Health Act and due to Sophie's mental health she was unable to protect herself from abuse and/or neglect at the time of the incident, which resulted in Sophie's death"*. It was noted that the timings of the incident were unclear, and that EPUT was finalising the report of its own investigation.

Inquest

253. Sophie's inquest was opened shortly after her death. Four pre-inquest review hearings took place before Sophie's the final inquest hearing, on 4 November 2022, 22 June 2023, 5 February 2024, and 8 March 2024.

254. In advance of the first pre-inquest review hearing, the Coroner, Tina Harrington, indicated that she considered that Article 2 would be engaged in Sophie's inquest. My solicitor applied for Exceptional Case Funding from the Legal Aid Agency on 28 October 2022 to fund our representation at the pre-inquest review hearing and the inquest.

255. On 17 November 2022, notwithstanding this, the Legal Aid Agency replied to my lawyers and said that funding was refused because of the *"early stage in the proceedings"* and because they wanted to consider the Trust's investigation report before granting funding.

256. Without Exceptional Case Funding, our lawyers would not have been funded to attend pre-inquest review hearings or the inquest on our behalf. This would have been hugely concerning for me and my family. We could not afford to pay privately for lawyers to represent us at the hearings, so we would have been on our own. This felt really unfair, particularly because EPUT was legally represented at the hearings, and the legal rules and proceedings involved were so complicated.

257. Fortunately, my lawyers still attended the PIRH in November 2022 and submitted an appeal against the refusal of funding. The refusal was overturned, and a certificate issued on 17 January 2023.

258. My lawyers made an application to the Coroner to invite her to request any potentially relevant unused and unedited footage of Willow Ward from the Channel 4 Dispatches programme because of the relevance of its findings to the period when Sophie was on the ward. That application was resisted by EPUT and ultimately refused by the Coroner.

259. In preparation for the inquest, planned pre-inquest review hearings were repeatedly adjourned due to delays in disclosure by EPUT – particularly of the PSII report which, as mentioned above, we were originally advised would be provided by January 2023 but was somehow delayed by around 8 months. EPUT provided extensive medical records for Sophie, and I have enclosed copies of these bundles with this statement. However, months into preparation for Sophie's inquest, EPUT disclosed a new updated bundle of medical records. This bundle had a completely different structure to the

previous medical record bundle, and the new material was not signposted. It was almost 4,000 pages.

260. The Coroner instructed a survivability expert, Dr **[I/S]**, to prepare a report regarding the emergency response following Sophie having ligatured. He criticised the emergency response as confused and disorganised, and found that for Sophie to have survived, she would have had to have been breathing and had a heartbeat when she was found by staff. He believed that her cardiac arrest was likely to have occurred at around 17:31, but emphasised that this was an estimate only and the true time could have been earlier or later. As a result, he was unable to say with confidence whether Sophie's condition would have been survivable if staff had responded to the Oxehealth alert when it sounded at 17:29, and considered that there was no prospect of her surviving by the point she was actually found.

261. The final inquest hearing took place for 5 days between 2 and 9 April 2024. That did not feel to me like enough time to have a thorough investigation into Sophie's death. Most of the witness evidence was read rather than heard live.

262. I attended every day of the evidence, along with my lawyers, and with the support of a family friend. It was a gruelling and distressing experience that I would not wish on anyone.

263. At the end of the evidence, the Coroner said that there was sufficient evidence for the jury to decide whether the following issues probably or possible contributed to Sophie's death:

a. The decision to downgrade Sophie's observations to Level 1 on 16 August 2022; and
b. The response to Sophie being found headbanging on 19 August 2022.

264. She directed the jury to return either a short form conclusion with a narrative, or a narrative conclusion.

265. Despite that, after only a few hours of deliberation, the jury returned a one-word verdict of "misadventure". I was surprised and disappointed by this conclusion, and concerned that the jury may not have understood the Coroner's directions. I did consider

challenging this conclusion with my lawyers but I was so exhausted by any prospect of having to relive another inquest..

Prevention of Future Deaths

266. During the inquest, on 5 April 2024, EPUT disclosed two witness statements addressing PFD issues.

267. The witness statement of [I/S], Service Manager for Inpatient and Emergency Services in Mid and South Essex at EPUT, read to me as predominantly an attempt to try to undermine or justify away, the evidence heard by the inquest in the preceding days, particularly regarding the level of restraint, and low staffing, on the ward. She suggested that the ward had been appropriately staffed for the level of acuity anticipated on the ward. She also suggested that, in contrast to evidence from the WM, there was no link between the increased use of bank and agency staff and the increased use of restraint, referring to data about the frequency of restraint on Willow Ward in the seven days preceding Sophie's death. She did not address the CQC report's finding that Willow Ward had both the second highest use of temporary unqualified staff, and the highest levels of restraint across the EPUT estate. She did, however, state that EPUT had undertaken a new drive to increase staffing ratios.

268. The witness statement of [I/S] Head of Deteriorating Patient Pathways and Resuscitation Training Officer at EPUT, addressed the emergency response training provided to EPUT staff, and suggested that new training had been implemented, and a new voluntary role of Resuscitation Link Practitioners introduced to promote best practice.

269. I did not feel, and do not feel, that these actions went far enough. Particularly when reading [I/S]'s evidence, I felt that the response of EPUT was more defensive than open and willing to learn.

270. The Coroner, however, ultimately decided not to make a PFD report.

My views

271. There are a number of particular areas of concern to me which I continue to have following Sophie's inquest, and which I would like the Chair to investigate as part of this Inquiry. These are:

a. Discharge planning;
b. Risk management and assessments in the community;
c. Medication;
d. Therapeutic relationships;
e. Restraint;
f. Staffing;
g. Technology;
h. Record keeping.

Discharge planning

272. I do not believe Sophie should have been discharged from Basildon Hospital in June 2025 – to me, the rapid decline she spiralled into after discharge was evidence of the fact that she was not ready to be discharged. She had been admitted to the Assessment Unit to await an available treatment bed, but she never received either treatment or a treatment bed. Instead, she was placed on high levels of medication, and high levels of observation, which appear to have temporarily suppressed her self-harming, and then discharged back into the community with no safeguards in place to support her, and with her underlying issues still present.

273. Putting aside the question of whether or not Sophie was actually ready for discharge, I also do not believe that the plan for that discharge was safe or adequate to Sophie's needs. Instead, I believe it set her up for failure. Sophie, a young woman with a storied history of non-compliance with medication or treatment, and a history of overdose, was discharged with significant quantities of medication in her own control, and her future support was hinged almost entirely on the need for her to register with a new GP, alone, without support. Her care co-ordinator was based in an entirely different geographic area so was not readily available to her.

Risk management and assessments in the Community

274. I am concerned at the apparent inefficacy of so many of the assessments Sophie received in the community.

275. In April 2022, Sophie was assessed by the Crisis team on 25 April, with known risks of suicidal ideation and self-harm, and presenting with evidence of neglect. Despite this, the action taken appears to have been minimal to non-existent. Vague references in records to Sophie being *"supported"* through the crisis, without any actual detail of what that support would look like, clearly were not enough to safeguard Sophie as she continued to decline. Three days later, she was telling the Home Treatment Team that she had suicidal intent, and all she appears to have been told was to go to A&E as a last resort.

276. In June 2022, after Sophie's discharge from the Basildon Assessment Unit, Sophie reported early relapse indicators within days of discharge. She told her care co-ordinator she had no food on 17 June, and that she had not been able to leave her home on 20 June. By 22 June – barely a week from her discharge – Sophie effectively communicated that she had relapsed. She told her care co-ordinator that she was hearing voices, had been neglecting to feed herself, and she was not taking her medication.

277. The initial assessment of Sophie on 23 June concluded at first that she had to be detained for treatment. However, appallingly, it appears that the decision was then taken not to detain Sophie because of delays identifying a bed. I am aware that the AMHP, **[I/S]** provided an alternative explanation in her witness evidence to Sophie's inquest, but this is not consistent with the account in the records at the time from Sophie's care co-ordinator, and I am not persuaded by it. It appears to me that rather than prioritising keeping Sophie safe, the decision was taken not to detain her on that first occasion because of convenience.

278. Again, having decided on a course of action that left Sophie in the community, the supposed "safety plan" agreed does not at all appear to have been adequate – relying on Sophie to take her medication, and accept treatment from the Home Treatment Team who had already, in my view, failed her in April.

Medication

279. By the time of her death, as far as I can see from her records, Sophie was being prescribed:

a. Depot injections of Clopixol, which I understand to be a long-acting anti-psychotic
b. Clomipramine at 200mg, which I understand to be an anti-depressant
c. Chlorpromazine at 100mg, which I understand to be another anti-psychotic with sedating effects
d. Mirtazapine at 30mg, which I understand to be an antidepressant
e. Pregabalin at 200mg, which I understand to be a sedating medication used to treat seizures, neuropathic pain, and generalised anxiety
f. Aripiprazole at 20mg, which I understand to be another anti-psychotic medication
g. Promethazine at 50mg, which I understand to be an antihistamine used for sedation, and to treat anxiety

280. This was a lot of medication for one person to be prescribed, particularly where they have a poor history of compliance with medication, a history of overdosing as a means of self-harm, are experiencing adverse side effects, and those medications do not necessarily appear to be leading to a long-term improvement.

281. Sophie's records are clear that she had been trialled on various medications to manage her mental health, but none appear to have succeeded in doing so – her symptoms persisted, and appear to have worsened over time.

282. The response, however, from clinicians seems to have been to either trial new medications on top of the old, or to increase dosages. On 14 May 2022, for example, Sophie's dosages of both Chlorpromazine and Aripiprazole were increased, seemingly in response to her reporting that the medications were not working. It appears to have just been the default answer to problems – medicate. I was particularly concerned to read in Sophie's records that nearing the end of her life, on 9 August, staff took the decision to increase her anti-psychotic medication despite the fact that they were expressing a lack of scepticism about whether psychosis was even present.

283. This is particularly concerning to me because I worry about the cumulative impact these medications had on Sophie. I note that in May 2022, after starting on Clozapine, Sophie reported that her new medication was *"kicking her ass"* and described dribbling, and light headedness. Around the same time she also developed the ulcers on her right ankle. She was later prescribed further medication – Hyoscine Hydrobromide – in response to her complaints that she could not stop dribbling, feel her body, or keep her eyes open. In July and August 2022, after each of her depot injections of Clopixol, Sophie appears to have been lethargic and fatigued, which is attributed by some

clinicians to the injections. Despite this, in both May and July, records also conflictingly state that Sophie was not experiencing any side effects to her medications. It is difficult to imagine they had any accurate picture of monitoring side effects given the poorly completed records about her compliance with them.

284. To the extent that Sophie's self-harm reduced following taking those medications, this does not appear to have been sustainable. Sophie was not compliant with medication, and she had developed paranoid ideation about taking her medication which she was very clear in expressing to staff. I question whether that paranoia may have been linked to her previous negative experiences around medication, like experiencing life-threatening NMS a few years prior, and whether it was linked to the very physical negative effects medication appears to have continued to have on her. On top of that, she had a history of taking overdoses, meaning that giving her large amounts of medication could present a serious risk to her life.

285. In those circumstances, I would have thought that person-centred care for Sophie would mean looking to reduce wherever possible her medications, and trying to find other ways to support and treat her that she might have a better chance of complying with, but this does not appear to have happened.

286. Prescribing more and more medication appears to have been a way to try to manage Sophie, not a way to treat her. The underlying issues – the voices she was hearing, the cycles of self-harm and suicidal ideation – were not being treated. Medication just appears to have been a way to try to paper over those problems without offering long-term or lasting solutions.

287. I am also, as I have discussed above, deeply troubled by Dr C's remarks at Sophie's inquest that he considered her concordant with her medication, although she had had to be restrained and threatened with restraint in order to comply.

Therapeutic relationships

288. As I have mentioned repeatedly above, it does not appear from the records that I have seen that Sophie had a therapeutic relationship with many of the staff on Willow Ward, but particularly with Dr C. She appears to have been in a state of heightened anxiety, characterised by finger clicking, and distress, both during and after every interaction she had with him. He appears to have been sceptical of her honesty when she reported

her symptoms, and in turn appears to have become a feature in her paranoid ideations – a fact she expressed clearly to him.

289. I am concerned that there may have been a gendered dimension to that. I know in general that publicly available research suggests that women are generally less likely to be believed, and their pain more likely to be underestimated, by doctors.[5] Sophie was also diagnosed with EUPD – which I understand is also sometimes referred to as Borderline Personality Disorder, which she had previously been diagnosed with. This is a diagnosis that I understand is disproportionately given to women,[6] and which can be linked to negative assumptions about the patient such as that they are manipulative, or malicious.[7] I am concerned that these interlinked factors may have played a role – intentional or otherwise - in the way Sophie and her needs were perceived by the professionals who were meant to be treating her.

290. Whatever the cause, I question why more was not done to try to build a therapeutic relationship with Sophie, or to change her consultant when it became clear that that relationship was negatively impacting on her.

Restraints

291. Sophie was restrained multiple times on Willow Ward, including repeatedly to administer medication. In his evidence to Sophie's inquest, Nurse **A** said that restraint is *"never pleasant"*. I hate to think about Sophie being restrained – held down by multiple people and forced to have injections of medication that she did not want, and had clearly expressed that she was afraid of.

292. While I have not been able to bring myself to watch the Dispatches documentary footage showing restraints on Willow Ward, I am aware that the quick recourse to restraint, and the methods of restraint used, have been criticised by experts consulted in the making of the documentary. I am also aware that the CQC noted in its inspection of EPUT wards that Willow Ward had the highest level of restraint of any ward across the EPUT estate. This leaves me with concerns about the sort of environment that was

[5] See, e.g. https://www.ucl.ac.uk/news/2021/apr/analysis-womens-pain-routinely-underestimated-and-gender-stereotypes-are-blame

[6] https://mentalhealth-uk.org/help-and-information/conditions/borderline-personality-disorder/what-is-bpd/

[7] https://www.borderlinepersonalitydisorder.org/pearls-from-beyond-borderline-the-experience-of-stigma-and-the-diagnosis-of-bpd-part-4-of-11/

fostered for patients like Sophie on the ward, how distressed, and ultimately afraid she may have been living in those conditions, under a threat of violent restraint if she did not comply with staff requests.

293. I do not know how Sophie was restrained, how many people were involved, how long she might have been restrained for, in what positions. I do not know if the restraints followed the procedures they should have, or how Sophie was supported or calmed after those *"never pleasant"* processes. It seems from her records that Sophie was very aware of the impact restraint had on her own therapeutic relationships, asking for particular staff not to be involved in restraining her because it would reduce her ability to trust them. I do not know if those requests were respected, or if an attempt was made to try to maintain those therapeutic relationships, and if so how.

294. I am left with fears that she, like the patients in the Dispatches documentary, was subject to unnecessary, inappropriate, or demeaning treatment that could have contributed to her decline in mental health.

295. I am concerned that there may also be a gendered dimension to the use of restraint. I know from publicly available research that women are three times more likely to be chemically restrained than men, and are generally more likely to be mechanically restrained than men too.[8]

Staffing

296. I know that EPUT's evidence to Sophie's inquest was that the ward was fully staffed on the day of Sophie's death, but I believe they attempted to obscure rather than address the problem. Firstly the supposed full staffing was only possible by recourse to a majority complement of bank and agency staff and the ward manager acting down and effectively working in two roles simultaneously. Relying on bank and agency staff means that there are fewer people on a ward who know patients well and who patients, in turn, know well. Who was Sophie going to be able to build a strong and trusting relationship with?

[8] https://restraintreductionnetwork.org/wp-content/uploads/2023/03/RRN_Inequalities_Explainer_FINAL.pdf

297. Secondly, and perhaps more importantly, even if the staffing levels were technically up to a standard EPUT were holding themselves to, that standard was obviously too low. Staff member after staff member gave evidence at Sophie's inquest that they did not have time to engage therapeutically with patients. The CQC also found that the lack of any psychology staff on Willow Ward was potentially a breach of Regulation 18.1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which is why they directed EPUT to ensure it had sufficient numbers of suitability qualified psychology staff to deliver care at Willow Ward and Cedar Ward, citing Regulation 18.1. How can it be considered by EPUT that there was enough staff on Willow ward in all of these circumstances?

Technology

298. I am very concerned about the use of Oxevision on Willow Ward and other EPUT wards. It is obvious from the records I have seen that Sophie was distressed by the presence of the camera in her room – she raised them in discussions with staff and they appear to have featured in her paranoid ideations about the government.

299. There is no clear record, as far as I have seen, of anyone explaining to Sophie what the Oxevision system was, or how it worked, let alone asking for her consent to use the system, or questioning whether she had capacity to consent. No one appears to have considered the potential negative impact on Sophie when she first arrived on either Basildon Assessment Unit or Willow Ward, and when she began expressing paranoid ideas about the cameras, that did not appear to prompt any review or consideration of whether their use was still suitable either.

300. Worst of all the system did not even keep Sophie safe. I question whether in her final moments she tried to cross the threshold to the bathroom in order to trigger a staff response. If she did, that confidence was devastatingly misjudged – no one responded to the alert, no one heard it. The security nurse who was meant to have custody of the tablet did not even know whether the ward had a tablet, and had no recollection of being trained to use the system. Seemingly, none of the staff were trained, because the Trust could locate no training records for the ward.

301. I am concerned, more widely, and particularly from all of the evidence I have seen to date in this Inquiry, that this system may be being relied upon by staff rather than conducting therapeutic care and in person checks, in the mistaken belief it will provide

a safeguard if things go wrong. When wards are understaffed, and staff are under pressure and Trusts are more concerned with costs to be saved from reducing staffing than the safety of their patients, I can see how easily that can be allowed to happen.

Record keeping

302. As I have repeatedly highlighted above, Sophie's records are incomplete, and perhaps more worryingly, inconsistent. As a bereaved mother trying to make sense of the unimaginable, this is so frustrating and upsetting. I look at the unexplained decisions not to update Sophie's care plans or risks assessments with key events, like ligatures, or the failure to even ensure basic information about ligatures like where they happened, is clearly recorded, and it reflects back a total lack of care. Clinicians are reliant on records – particularly where there is high turnover in staff, or the same staff are not seeing a patient every day. How can they make informed decisions without adequate information? How can they keep patients safe if they do not know what risks they should be keeping them safe from?

303. I know that the CQC found in its inspection of Willow Ward, repeated issues with care plans and risk assessments not being properly updated. It's awful to know that the paucity of record keeping in relation to Sophie appears to be the rule rather than the exception.

Recommendations for change

304. The Inquiry has asked in my Rule 9 request what recommendations for change I would like to ask the Chair to make. There are discrete issues I think would make a difference to the care of vulnerable people like Sophie, and maybe help to keep them safe – like removing systems like Oxevision from patient bedrooms, or improving staffing levels of qualified and properly trained staff. I also believe that there are measures that could be recommended that would help families like mine to hold Trusts and other bodies to account when things go wrong – like implementing a single, clear, independent oversight body that is accessible, transparent, and publicly accountable.

305. However, I believe problems run deeper than that. Fundamentally, I am concerned that we as a society, and in particular those responsible for mental health care, have become too complacent and comfortable with the loss of life within that system.

306. There is a cost benefit analysis too often conducted by those in power when it comes to safety. The cost of taking adequate measures to improve safety or reduce risk, weighed against how many lives might otherwise be lost. The question does not become how can we stop losing lives, it becomes how many lives are too many? It took over two thousand deaths for this Inquiry to come into being.

307. If two thousand people had been hit by cars on the same motorway, I believe there would have been action far before that number was reached to keep people safe. Perhaps, because in that scenario there would have been a clearer pathway for those impacted, who recognised urgent action was needed, to lobby for or implement urgent change. My fear is that in the sphere of mental health, the calculation is a skewed one because of the de-valuation of lives in the context of mental ill health, and the normalisation of their loss. I never want the question to be "how many deaths is too many?" I want the recognition to be that even one death is too many – that there is no acceptable level of loss in the provision of mental health care. That every life – every Sophie – matters.

308. Our mental health system does not seem to be working – it does not seem to me to be treating mental health. I look at Sophie's experience in EPUT's care. She enters hospitals for treatment, to be kept safe. There, she is medicated at times by force, and her safety enforced by restrictions that aim to remove the opportunity for her to hurt herself. She receives no therapeutic input beyond that. I understand that the treatments for EUPD and schizophrenia are meant to be psychotherapy. I have not seen any evidence Sophie received any form of psychotherapy on either Basildon Mental Health Assessment Unit, or Willow Ward. On Willow Ward, she could not do so – there were no psychology staff and no plans to recruit any when she was on the ward. Without genuine therapeutic input, mental health wards become silos – holding pens where people can be locked away out of sight for a while in the hope, rather than expectation, that their symptoms will improve. When Sophie was discharged into the community, it was without adequate follow up, without adequate support. The restrictions the hospitals had placed on her – the coercion required to deliver the medication that kept her sedated, or the physical presence of staff to intervene – were gone, and without them she fell off a cliff edge. The cycle repeats itself.

309. Dr C used the term "*revolving door patient*" to refer to people like Sophie who find themselves in and out of hospital. I do not like that term. We say it as if the onus is on the people going through crisis and struggling with their mental health to free

themselves from the pernicious cycle of admission and discharge, even where they have not received the treatment or support that would enable them to do that. We do not acknowledge that, to have "*revolving door patients*", the system as it currently functions has to be a revolving door, intermittently pulling in and spitting out our most vulnerable without really effecting change for them.

310. The same mental health system then steps in to explain away each death as an exception. Institutional defence then characterises the investigations and inquests, and interactions that follow, and the bereaved are made to bleed for every acknowledgement, every admission, and every demand for change. Families like mine struggle with minimal support through overlapping, obscure processes that are so frequently designed to exclude or silence us, and too often at the end find no or hollow vindication.

311. For me, the main change that I want to see following the conclusion of this Inquiry is that people, and the mental health system, do their jobs. The function of the mental health system should be treating mental ill health, putting patients' well-being and therapeutic treatment at the heart of the system, keeping them safe and supporting them to live fulfilled lives. It is woefully failing at that, and too often defending and entrenching those failures where they do occur.

Documents

312. I have provided a list of relevant documents which my solicitor holds in relation to Sophie's care and death in Annex 1 to this statement. These are predominantly documents which were disclosed to me following Sophie's death and in advance of her inquest.

STATEMENT OF TRUTH

I believe the content of this statement to be true.

Signed: **[I/S]**

Name: Tammy Smith

Dated: 10.09.2025