WITNESS STATEMENT OF CRAIG SCOTT
PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, Craig Scott, [I/S] of [I/S] [I/S] am the son of Iris Scott (5th December 1940; DOD: 1st March 2014).

2. I make this statement based on my own recollection and documents relating to mum's medical care; her handwritten notes from her final admission; the handwritten notes of my sister, Dawn Johnson, from mum's final admission; and my witness statement for the inquest into my mum's death in 2015.

3. Dawn has provided the Inquiry with a statement dated 27th May 2025. I have found the Inquiry process very difficult, given the impact that mum's death and subsequent events has had on my mental health, which I will expand on below.

4. For these reasons, I have asked my legal team not to go through every Rule 9 question with me, as Dawn would have previously done so, and I fully adopt the answers she has provided to the Rule 9 questions which I have not been able to answer. I note that Dawn and I have very much been side by side throughout mum's final admission and this process.

5. Therefore, in this statement I focus on the questions that only I can deal with, perhaps because I was the one present at Ruby Ward ("the ward") at the same time, or because I am offering my own opinion.

6. I take this opportunity to note for completeness that it was not until the process of finalising our statements in response to the Inquiry's Rule 9 requests, that I became aware of very concerning records of events concerning mum's care and treatment. For example, I was not aware that the staff on the ward recorded that they considered they need to listen to mum's telephone conversations with family, or that mum was still recorded as being technically alive (responsive cardiac arrest) when the ambulance crew arrived at the ward on 1 March 2014. This was very upsetting.

Background

7. In my commemorative statement to the Inquiry, I explained who mum was and what she was like as a person. We noticed that mum's behaviour changed in 2007. I remember that my wife and I had organised a party for our family and friends in November 2007, at which mum was withdrawn. This was out of character for mum.

8. In December 2007, we became more worried about mum, so we took her to The Priory on 4th December, when she was assessed by Dr [I/S] Dr [I/S] prescribed some medication for mum. Mum's condition deteriorated in early 2008. She started pacing up and down and was unable to relax. I remember receiving a phone call from Dawn who was concerned about mum.

9. We decided to call the Mental Health Crisis Team. Dr [I/S] gave mum a sedative and was treated at home rather than as an inpatient. After a short period, we noticed the medication was taking effect and mum's condition improved dramatically and was back to normal within a few weeks. We all noted, *"we have our mum back".*

2013

10. Mum began to experience some dental problems in early 2013. She was not able to get a dental appointment for some weeks. This affected her sleeping pattern. There were other problems going on at the time too which Dawn explains in her statement. Mum was finding it difficult to rest. I remember that mum told me she was worried that she would get unwell again because she could not switch off.

11. I understand that mum went to see her GP about this around this time. Shortly after, around May 2013, mum was referred to the Crystal Centre as an outpatient. I understand that an appointment was made for mum to meet with Dr [I/S] on 26th June 2013, with another appointment to take place in July 2013.

12. I think it was because of these visits that it was decided that mum needed a care worker. I think it was around this time [I/S] started as mum's care worker. The CW visited mum at home, as did Dr [I/S] However, mum's condition was not improving. We noticed that mum became more agitated about the lack of progress with her condition. She frequently challenged Dr [I/S] about her medication, asking him to change it, which he would do. Mum was a very strong character, and I do not think

that Dr [I/S] was, because it seemed wrong that he was switching her medication on her request.

Mum's admission on 30 August 2013

13. Mum was admitted to the ward on 30th August as a voluntary patient. She was only meant to be there for three weeks.

14. Dad and I attended the admission with her. It is difficult to remember the exact process on this day, because it is over ten years ago now. Some of what I remember will be a direct memory whereas other parts of it will be vague memories.

15. I think that the process on that day involved me travelling to our parent's home to collect mum and dad, with the CW with us on the way to the ward in her own car.

16. On arriving at the ward, we waited in reception together. It felt like a very long time, but it might not have been. I remember that there were a lot of other patients from the other ward in reception. They were of a younger generation, and they were in and out. It was off-putting because some of them were noisy and vocal. I felt that it could be upsetting for mum.

17. We were then greeted by the ward manager at the time. The nursing staff gathered some paperwork. There were some discussions between the nursing staff and a doctor. It was confirmed that mum was a voluntary patient. We understood that mum could leave at any time. I am not sure if mum understood this, given her mental state at the time.

18. I do not remember any documents being signed, but I am sure that there would have been some documents and dad, as mum's next of kin, would have signed them. I suspect that we did leave with a leaflet of some kind, but I cannot remember if we picked this up ourselves from reception or if this was handed to us by staff.

19. Leaving mum at the ward was one of the most difficult things I have ever done. Dad was heartbroken. Mum was very upset. Outside the ward, dad and I had another conversation with the cw We discussed that this was the best option for mum at the time.

Ward environment

20. I would visit mum at the ward. My overall observations are that the staff did not keep mum occupied when she was there, not at the level that she needed. Although mum was there because she was struggling with her mental health, her brain was still very much active – for example, she would do sudoku and play cards. She retained her functionality. So, to be on a ward like the one she was on and to not be stimulated made her bored and increasingly frustrated. She was not engaged, and she had nothing to focus her mind on. When we would visit mum, she was always doing an activity on her own. If she was doing any group activities – which we would not have been present at to witness – I guess they would have been catered for the average patient there, with mum probably being on the top end in terms of functionality.

21. The ward was always clean. At times, the security was less than desirable. For example, mum was able to wander the grounds on her own, and I remember one of the other patients gained access to an area of the ward causing a, *"You shouldn't be here, get out"* type of incident.

Staffing, training and support

22. In the early weeks of mum's admission, I probably did not have many concerns about staff. At this point I did not know how such systems operated, or how they should have worked.

23. As time progressed, we started to see red flags, not just over mum's care and treatment but also over the so-called professional environment. I recall that other patients would help each other off the floor, guiding them to their room because there were no staff around at those points. These were not isolated incidents.

24. Even in the first two to three weeks, I remember that there was a woman serving coffee from a hatch and then shortly after I saw her on the ward dealing with patients doing non-clinical carer-type roles. In a clinical environment this seemed odd to me.

25. It was clear that the system there was broken. The staff did not seem confident in their roles. I do not have any specific examples of this, given the passage of time, but this is my general memory of the ward. I remember feeling as though the staff had been

pushed through the system very quickly because the ward needed an appropriate staff headcount, both in numbers and/or with the applicable qualification(s) and grade(s).

26. Even still, too many times they did not have enough staff on the ward. I remember once that there was a gentleman who was helping people, with no other staff around. I think I said something to him along the lines of, *"Your work is never ending, isn't it?"* and he replied with something like, *"I don't work here, I'm a patient, mate."*

27. When there were security incidents, the lack of staff was a problem. There was an incident in the other ward once, and most of the staff had to leave to go to that ward, leaving one member of staff on mum's ward where there were around 15 vulnerable patients.

28. Dawn has outlined in her statement our concerns about the staff's attitude towards us as a family and towards mum. I remember once, mum told us, *"You don't know what it's like in here … they're not very nice to us".* At a later date, whilst we were sitting with mum on the ward, we would hear another patient express exactly the same thing to her relatives. I do not have any evidence to suggest there was violent physical abuse involving patients being struck, but mum once implied that a tall male member of staff, [I/S] I think, had sidestepped towards her, obstructing her passage (rather than give her ample space to walk freely) as she walked towards her room.

Treatment, care and diagnosis

29. I do not think mum ever had a clear diagnosis. For the full six months that mum was in their care, the clinicians did not get to grips with what was wrong with her. So how could they have treated her?

30. I remember that Dr [I/S] was removed from mum's care on 30th November 2013. At this time, we still had no idea what mum's diagnosis was. There was no formal diagnosis or clear care plan in place. It seemed to me that mum had been given a series of different drugs in the hope that some may work. In fact, that was what Dr [I/S] had previously implied when he said something along the lines of, *"There are lots of different drugs that we can try. We will find the right ones eventually."* I thought this was very strange.

31. I remember we were asking the staff and clinicians to give mum PRN sedatives. There was one occasion when I was at the ward, when Dawn was on holiday I think, when there was a nurse looking after the ward. I think the nurse was a contractor. Mum was very agitated and in my view, as her son, this was her biggest problem which needed urgent treatment. I remember asking the nurse if mum could be given something to settle her down. The nurse said that she was able to give mum PRN but that she did not think that the other medical staff would make this decision. In the end, she did give mum the medication and I remember mum was settled for a short period of time.

32. I have a very good friend who lives in Australia, who owns and manages a clinical psychology practice (for over 20 years). Coincidently, he was visiting the UK during mum's attendance on the ward (early January 2014 I think). I remember at the time speaking to him about our concerns about mum's treatment and medication. His advice was that the symptoms must be treated first, not the patient. Dawn and I raised this with the staff on different occasions. We wanted them to deal with her anxiety first which we believed was her biggest presenting problem, and then when she was settled, to try to treat any underlying issue(s). But the staff would tell us that while the sedatives seemed to work back in 2007 and 2008, we were back at hospital years later so clearly those treatments did not actually work.

33. Up until mum's first ligature attempt on 14 January 2014, our conversations with the staff were all about her medication. From our perspective, she was not getting any better. Whatever the ward was doing to try to treat her was simply not working.

34. Looking back, I would probably have had a bit more faith in the medical staff if they had just presented a clear plan for mum and said, *"We know best and we are going to do this route"*, without changing the plan so frequently. Instead, they were changing their approach constantly which to me showed that they did not know how to treat mum.

35. What did not help an already complex situation, was that mum's psychiatrists were constantly changing. I believe mental health assessments are very subjective, it is not like injuring your arm and then having a doctor confirm with a scan that you have broken it. Mental health issues are not clear and obvious. Individual practitioners will take different approaches, and they will form different opinions. So, in mum's case I think this was magnified, due to the constant changing of psychiatrists, who kept

forming different opinions and jumping to different conclusions from one to another about mum's diagnosis and treatment.

Safety

36. Dawn's statement outlines in detail all the safety incidents and associated discussions and meetings. I will add to some of these points here.

37. On 24th October 2013, I understand that mum made her first threat to self-harm when she was on the phone to Dawn. I understand that Dawn reported this immediately to the ward staff and manager. Dawn explained this to me, and she was surprised by the ward's lack of concern and not taking what she had told them seriously.

38. It was around this time that mum had started to make comments to me expressing her concern that she was not getting any better, that she could not live like this, and that we did not know what it was like at the ward. Because of this, I was very guarded with the staff – especially the senior staff – because I was worried that if we raised any concerns then it could have repercussions for mum.

39. On 16th January 2014, I received a phone call when I was at work. It was from Dawn, and she told me that there had been an incident at the ward. She asked me to get there as soon as possible, which I did. When I arrived there, I met with Dawn in the reception area, where Dawn explained to me that mum had attempted to ligature on 14th January and she was injured. She said that the ward staff claimed that mum had fallen over, damaged her tooth, and bruised her face; but that mum had told her she had tried to hang herself. Dawn believed mum and she was very distressed. I was obviously very concerned at this point.

40. When Dawn and I walked onto the ward on this day, we were told that mum had been sent to her room because she was very agitated. When we went to see mum in her room, mum was arranging a cord and the chair in her room, in a way that was consistent with what she had described to Dawn about how she had tried to ligature on 14th January. This was very disturbing to see.

41. I immediately went to the reception. I asked the administrator who was sitting at the nurses' station to find some nursing staff as there were none visible on the ward at the time, stressing the urgency of the situation and that someone needed to see and

address what Dawn and I had just witnessed. When two nurses finally turned up to mum's room, they were shocked. They started to search mum's room, and we were asked to wait in the reception.

42. As we were waiting in the reception, [I/S] the senior member of the nursing staff, approached us. I do not recall [I/S] ever saying more than a few words to us (in fact she would try to avoid us and, in some cases would refuse to discuss mum's care with us) at any point from the day mum was admitted, on 30th August 2013, before this point, unless we were in a care meeting. Straight away, I thought that the ward knew this was a serious failing from a controls and safety perspective, which could have serious repercussions, if they were sending [I/S] to speak with us.

43. Mum was then allowed out of her room to sit with us in the ward. She was very agitated and was pacing around saying, *"No, no, no".* I kept asking mum to calm down and to stop pacing around. It was here that mum kept saying, *"I've done it now, I'll be in so much trouble".* She suggested that she could just say that she fell.

44. As a result of this incident, we attended a CPA meeting at the ward on 23rd January. Before the meeting, we met with [I/S] the clinical manager at the time I think, and [I/S] During this meeting they both accepted that mum had attempted to ligature on 14th January. I made the point that I felt that if Dawn and I had not come to the ward on 15th January, then the ward would have intimidated mum, she would have changed her story, and the incident would have been covered up.

45. At the CPA meeting itself on 23rd January (and even during another one on 11th February), I reiterated my concerns that the plan for treating the underlying cause (which what it was they did not even know) rather than mum's presentation was wrong and not working.

46. Dawn has outlined the various points that we discussed at the CPA on 23rd January, and I take this opportunity to add a few further points, based on my recording of the meeting.

    a. I asked the staff, *"With the process, if I wind back a bit, has this happened before on this ward? Attempted suicide? So, the plan that's in place would be off the bat or is there a code of practice that we have to follow?"*

A staff member replied, *"We have, I mean obviously we have suicidal patients very frequently, we are very fortunate that the level of observation that we usually have people on has prevented serious attempt or anything like that. So, any management plan has to be tailored to the individual. One of her main issues is her huge level of anxiety so that's part of what they have got to ... engage with her which will be very, very difficult when she's like this but it's their job and it's what they paid to do."*

b. Dr [I/S] explained that mum could be placed on Section 3 of the MHA, but that given her *"personality issues"* she did not think that mum would want to have a staff member with her all the time. I responded that, maybe having a staff member with her all the time would help her because she needed attention. Dr [I/S] said that in her experience this would do more harm.

Leave

47. Dawn has addressed the circumstances around home visits and leave processes and security on the ward. I would like to make two additional observations.

48. From the lobby of the hospital, mum's ward was off to the right. To enter the ward, we would buzz the door and announce who we were and who we wanted to visit. The door would be opened for us. There was another door which we would have to buzz again, and nursing staff would have to open that one. We would walk to the nursing station and sign in with our name and date. That was the general process, but it probably did not go that way all the time.

49. On 19th December 2013, the day before mum was sectioned, mum had been able to leave the ward unaccompanied and walked straight into the car park. My understanding is that at this point mum was highly agitated and ran towards dad's car. I understand that Dawn asked the staff why she had been able to leave the ward in that state. She was told that mum had told the staff that she was just going to sit in the reception area.

Engagement and complaints

50. The only engagement that we had with staff on the ward was when we initiated it ourselves. If we asked how mum was, we would get an answer, but we would usually have to push for answers. We asked open questions, hoping for clear answers, but some of the more junior staff would not be able to answer those questions.

51. In the end, I think that the ward staff probably saw us as a difficult family. It seemed to us that the staff did not want to engage with us. I think it was the ward manager or [I/S] who one day said to us in response to a question, *"I don't want to discuss this with you, you will have to speak to the doctor."*

After mum's death

52. On the morning of mum's death on 1st March 2014, Dawn, dad and I went to the ward. I remember the staff referring to mum as, *"the body",* which to me demonstrated the lack of training throughout the ward and the lack of empathy or compassion they had. It also revealed that some of the staff appeared detached and unaware of the vulnerabilities of the people that they were dealing with and their families.

53. One of the biggest points that stuck out to me on this day was that at no point did anyone working at the ward say something like, *"Sorry for your loss",* or ask how we were. If felt like they wanted us off the ward as soon as possible.

54. In terms of the investigation that followed mum's death, when it started things were still very raw for us as a family. There was no clear process, and it felt as though we were being dragged along from one hurdle to the next.

55. I recall being offered a meeting with the SIR team just a few weeks after mum's death, around the time of her funeral and dad's birthday. Dawn and I said to each other that we were not ready for the meeting at that time.

56. We had a meeting with the SIR team eventually, and I remember coming out of that meeting feeling very angry. In the end, the report dated 8th June 2014 appears to be a copy and paste job or a template document – they even got mum's name wrong in the report, referring to her as *'Mrs Smith'*, which demonstrated the lack of concern by the Trust to want to clearly identify what had happen and understand how these incidents

could be avoided. It also showed a complete contempt towards us as a bereaved family.

57. Beyond that, I was shocked by parts of the SIR which were totally inconsistent with mum's care, which Dawn has outlined in her statement. For example, it did not go into detail about how the scarf mum allegedly hanged herself with came to be in her possession, or how her room was or was not searched. The staff observations and responses did not align with the PAC Tag report which we eventually obtained. Even to my untrained eye, the SIR was not worthy of further consideration. Instead, it added to our distress and suspicion about how mum had died.

Other proceedings

58. An inquest into mum's death took place in June 2015. I found this process difficult because I had not been in a courtroom before, let alone a witness as a bereaved son. The strongest feeling and memory that I have from the inquest is that it felt as though the coroner was against us and was instead leaning towards NEPT. The coroner would not allow us to admit evidence which we said was factual – this being the tape recordings that I made.

59. There was another factor that led me to think that the coroner was against us. The coroner decided that mum's personal and private issue from years back was relevant to her investigation, even though in the end it appeared to have no relevance to the outcome. This caused our family significant distress.

Impact on me

60. I was not aware of how much mum's experience at the ward and her death impacted me, until later. I am now very emotional and struggle to keep my emotions intact. I have had counselling to help me cope with this and manage my emotions. Although I have not had an official diagnosis by a doctor, a second counsellor that I went to see told me that I was depressed. Following these sessions, my mental health has vastly improved but I still feel an overriding sense of loss, emptiness and anger. I strongly believe the events leading to my mum's death, could have and should have been avoid.

My views and recommendations

61. There have been over 2000 deaths in the Essex mental health NHS Trusts. All the obvious recommendations will have been made already. For example, in Prevention of Future Deaths Reports. They are obviously not being addressed. No one was, and no one is listening – there seems to be zero accountability and that installs a lack of urgency by the Trust(s) to remediate these recommendations. For example, it has been long reported that there are ligature points which need to be removed – and yet, they were not. I think that this comes back to the one thing that everyone wants but no one can get: funding. A small budget used wisely, is better than a big budget poorly managed. The NHS Trusts are businesses. They do get funding but because of their inefficiencies they waste it. I have no trust or faith in the system anymore.

62. In addition to the above, I will go one step further to explain why my feelings and senses are having lived through this ordeal. This situation is like the cost impact of battlefield casualties – where the cost of death is likely far less compared with the cost of rehabilitating the wounded. Maybe it is considered by the government that it is just cheaper to not adequately fund or treat the most vulnerable in our communities, including mental health patients.

Statement of truth

I believe the content of this statement to be true.

Signed: [I/S]

Name: Craig Scott

Date: 27th May 2025

ANNEX OF EXHIBITS

ACCOMPANYING THE WITNESS STATEMENT OF CRAIG SCOTT

PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

DOCUMENT	EXHIBIT REFERENCE
Craig Scott's tape recordings of meetings with Iris Scott's mental health team at NEPT	**CS/1**