WITNESS STATEMENT OF CAROLE STOKES PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **Ms Carole Stokes** (DOB [I/S], of [I/S] [I/S] am the mother of Lee Henry Spencer (born on 23 September 1998; died on 27 August 2019.)

2. I am making this statement from a combination of own my own memory of events, knowledge, belief and having access based on my memory of events, from having seen my late son's records / other disclosure and the evidence placed before the inquest (into my son's death), which was held on 4th February 2020.

Diagnosis

Early Years

3. When Lee was growing up, he seemed like a typical boy. As noted in his medical records at page 10 of the inquest bundle, I once described him as *"bad tempered,"* but he was never violent or aggressive. At that time, I had no concerns about his mental health.

The Onset of Mental Health Issues

4. In my view, Lee's mental health difficulties truly began in 2016, when he was 17 and had just left secondary school. However, to properly explain the development of his mental health issues and when I first noticed he was becoming unwell, I believe it is necessary to outline what I consider to be key contributing factors that predated 2016. These include the lack of timely assessment for ADHD, the absence of a relationship with his father, challenges faced during secondary school, and his struggles with his sexuality.

Undiagnosed ADHD

5. I strongly believe Lee had undiagnosed ADHD and that not receiving treatment for it played a significant role in the decline of his mental health.

6. During secondary school, I was occasionally called in due to Lee's hyperactive behaviour. To support him, the school assigned a mentor who would work with him to calm him down and help him concentrate. Lee also took part in several after-school activities to help channel his energy. Despite this, no school staff or professionals ever suggested an ADHD assessment.

7. When Lee was around 16, he confided in me that he thought he might have ADHD. I advised him to see a doctor. This is recorded in his medical records at page 18 of the inquest bundle, noting that during his assessment on 1 June 2019, I informed Dr [I/S] that when Lee was 16, he told me he needed testing for ADHD, and I advised him to speak with a GP. He did make appointments but never attended them.

8. Lee later blamed me for not making him attend these appointments, but as he was 16, I didn't feel I could force him to go.

9. I believe that not being assessed earlier was a major factor in the development of Lee's mental health issues at 17. With an earlier diagnosis, he could have received appropriate support, such as tailored educational assistance, therapy, or medication. Instead, Lee struggled for years with issues in attention, organisation, and emotional regulation, issues that were often mistaken for behavioural problems. This led to frustration, low self-esteem, and a growing sense of failure, which I believe compounded and contributed to his mental health decline.

10. Early identification and treatment of ADHD is crucial in helping young people manage symptoms and prevent secondary issues like anxiety and depression. For Lee, missing this window of opportunity left significant difficulties unaddressed at a vital stage in his development.

Lee's Relationship with His Father

11. I also believe that Lee's lack of a relationship with his father contributed to his mental health issues.

12. As detailed in my commemorative account, Lee lived with both of us until he was four years old. After my marriage ended, Lee lived with me and his siblings. This is

confirmed in the GP records at page 13 of the inquest bundle, which state: *"Parents separated when Lee was 4 y/o. Carole stated that Lee has withdrawn from his father out of choice but for no apparent reason and does not respond to his father's messages or calls."*

13. While I don't believe this was the main factor in Lee's mental health issues, the lack of paternal involvement from a young age likely affected his emotional development. Lee often expressed feelings of abandonment, and I believe this led to unresolved emotional needs and a diminished sense of self-worth. Combined with other challenges, such as undiagnosed ADHD, this further strained his emotional wellbeing.

Secondary School Experiences

14. Some of Lee's experiences in secondary school also likely contributed to the development of his mental health difficulties.

15. According to page 10 of his medical records, Lee reported that he had *"behavioural problems"* at school because he *"couldn't control himself, couldn't sit still and struggled with concentration."*

16. I later learned from Lee's brother that he was involved in several fights during secondary school. One particular fight seemed to leave a lasting impression on Lee. He believed he had lost the fight over a girl he was seeing, which appeared to deeply affect his self-esteem and confidence. He was feeling let down and concerned that there would be further issues. Lee did not go out for a while until his brother spoke to the other people involved.

17. Lee told Dr [I/S] at EPUT, as noted on page 10 of his medical records, that *"he was beaten up at school aged 16 y/o and his depression started from there."*

18. Although I wasn't aware at the time that Lee had been beaten up, I did notice behavioural changes in him around that period. He began hiding things from me, which I now believe may have been linked to this incident.

Sexuality

19. In 2018, Lee confided in me that he was bisexual. Until then, I had not known he was interested in same-sex relationships. When he did open up, I was very supportive and tried to provide a safe space for him to speak openly, without judgment.

20. I believe that prior to opening up, Lee struggled internally with his sexuality. Dealing with this in the context of adolescence and the school environment, where teenage reactions can be unkind, may have added to his emotional distress.

First Signs of Mental Illness

2016

21. Around 2016, when Lee was 17 and had just left school, I first noticed signs of his declining mental health. While I now believe he may have had earlier symptoms during school, the structured environment may have masked them.

22. After moving on to college, Lee struggled more visibly. He had difficulty processing negative events and would often need long conversations to work through issues that others might brush off. He also had a difficult relationship with a girlfriend that year, which caused him significant emotional distress. Although not severely unwell yet, I believe this marked the beginning of a steady decline.

2017

23. In August 2017, we moved to **[I/S]**, hoping a fresh start would help Lee. He was pleased to leave **[I/S]** behind and hoped to stop smoking weed. However, he quickly found a new supplier and continued smoking. He said it helped *"make his head feel better"* and provided temporary relief from his emotional distress.

2018

24. By the end of 2018, Lee was regularly using cannabis and experiencing more frequent emotional episodes. Around this time, he confided in me about his sexuality. He told me he wanted to be a husband and father but also enjoyed aspects of being bisexual, which he found confusing. I reassured him that love is love and that he could still have the life he envisioned, regardless of his sexuality.

2019

25. By January 2019, Lee's struggles were worsening. I encouraged him to visit the doctor.

26. On 25 January 2019, Lee saw Dr [I/S] at Coggeshall Surgery. As recorded on page 5 of the inquest bundle, she noted depressive symptoms, bisexuality-related concerns, past suicidal thoughts, and that he had tried to hang himself the previous year but had stopped. He was offered treatment options.

27. On 30 January 2019, Dr [I/S] prescribed antidepressants and discussed reducing cannabis use. Lee was reviewed again on 15 February 2019 and was still struggling with his identity.

28. Lee took antidepressants for approximately 6–12 weeks. Initially, they helped, but in April 2019, he told me he wanted to stop as he no longer felt depressed. I advised him to speak to his doctor first, and he requested a callback, but the GP never followed up. Feeling ignored, Lee stopped the medication and refused to engage with the GP again, saying she didn't care.

29. I truly believe the lack of a follow-up call deeply affected Lee and led to a worsening of his mental health.

Crisis Point – 01 June 2019

30. That morning, Lee's phone stopped working, which caused him significant distress. I had planned to visit his sister and told him we would sort the phone afterwards. Lee became agitated and left the car to calm down. He walked home instead of returning with us.

31. At home, Lee was withdrawn. He told me he needed urgent help or he might hurt himself or someone else. I called NHS 111, who assessed him over the phone and instructed me to take him to Broomfield Hospital for an emergency mental health consultation.

32. We arrived at 19:41, as confirmed in a letter on page 6 of the inquest bundle. Lee was assessed, and although the team felt he could be managed in the community, Lee

insisted he needed to be admitted or he would hurt someone to get the help he needed. Despite this, no bed was available.

33. After waiting for hours, we were told there were no beds in the country. We were promised one would be found the next day. Lee was upset but reluctantly agreed to return home after I reassured him.

34. I was shocked and deeply concerned by the lack of available beds. I ask the inquiry to investigate how this could be the case for someone in such clear need.

Admission to The Lakes – 02 June 2019

35. The next day, Lee received a call informing him that a bed had been found at The Lakes. I took him there, and he was calm, hopeful, and relieved. He was admitted voluntarily and stayed for four days. I visited daily and spoke with staff about his condition. During this time, Lee appeared positive and engaged.

Diagnosis – 06 June 2019

36. On the final day, Consultant Psychiatrist **[I/S]** diagnosed Lee with Emotionally Unstable Personality Disorder (EUPD). He explained the condition and advised that hospitalisation was not required. Lee was told he would not need antidepressants but would benefit from therapy. He seemed happy to finally have a diagnosis and looked forward to managing his condition with support.

Assessment on 01 June 2019

37. As noted earlier, Lee underwent a crisis mental health assessment between 20:46 and 22:00 by **[I/S]** of the Broomfield C-Raid team. I was present and able to share my concerns and provide background information. Pages 14–19 of the inquest bundle contain full details of that assessment.

38. I have significant concerns regarding the outcome of Lee's Mental Health Liaison Team (MHLT) assessment on 1 June 2019. I ask the Inquiry to investigate why, following this assessment, Lee was not detained under the Mental Health Act 1983 (MHA). As outlined in the assessment summary, Lee was clearly in crisis and was openly expressing suicidal ideation and potential harm to others. Despite this, I do not believe

that Broomfield Hospital seriously considered detaining Lee under the MHA to safeguard him and those around him.

39. [I/S] the assessing clinician, stated that sectioning was not considered because Lee believed medication would not help him. However, my understanding is that under sections 2 or 3 of the MHA, medication can be administered without consent. Given this, I cannot understand why sectioning and subsequent treatment, possibly including medication, was not seen as a viable option.

40. According to the Root Cause Analysis (RCA) report, the plan after this assessment was to refer Lee to the Home First Treatment Team (HFTT) to determine the most appropriate intervention, whether that be inpatient admission or home treatment.

02 June 2019 – Home Visit by HFTT

41. On 2 June 2019 at 12:30pm, Lee was seen at home by a Community Psychiatric Nurse (CPN) from HFTT. I was present during this visit. Initially, Lee appeared calm and was asked if he could be available to see a psychiatrist on the following day or Tuesday 4 June.

42. However, when this was suggested, Lee became increasingly distressed and angry, shouting that nothing was being done to help him and that *"something would happen."* He paced the room, agitated and tensing his arms, before moving to a corner in frustration. I asked him to stay in the room, and the CPN advised he could leave temporarily if he felt the need.

43. Lee returned and sat down, still visibly upset. When asked how he felt about being admitted to hospital, he clung to my arm, sobbing. He was told that restrictions, such as limited smoking, would apply, to which he replied he was fine and he was desperate for help.

44. A bed was arranged on Gosfield Ward at The Lakes in Colchester. The HFTT formally referred him to the Adult Inpatient Wards, and Lee was admitted as an informal patient later that day.

Admission to Gosfield Ward – The Lakes (02 June – 06 June 2019)

45. During Lee's admission, we were not formally informed in advance of any assessments being carried out. Although information was sometimes mentioned in casual conversation, we were not properly consulted as a family.

46. I believe Lee was not mentally capable of processing the information given to him during this time. In light of this, the mental health team should have informed us and his family, of the assessments and plans for his care. No written documentation, consent, or formal communication was shared with us, and we were only informed of the EUPD (Emotionally Unstable Personality Disorder) diagnosis after it was made.

47. We were told Lee was being admitted as an informal patient but not given clear details about the decision-making process behind this. According to his records, the HFTT referred him to Gosfield Ward and he was admitted at 4:00pm on 2 June. An admission assessment, conducted at 6:08pm by Dr [I/S], stated Lee presented with active suicidal ideation, was non-compliant with his prescribed medication, and was emotionally volatile.

48. Lee remained at Gosfield Ward for four days. In hindsight, I believe he should have been sectioned under the MHA, not admitted informally. While I trusted the professionals at the time, knowing what I do now, I would have strongly advocated for sectioning to ensure Lee's safety.

49. The family was not given adequate information during Lee's stay. Greater involvement from us could have supported Lee's care and provided vital context to his needs.

Ward Environment

50. While on the ward, Lee appeared to be treated well. He ate properly and, because he was not sectioned, had the freedom to leave the premises, which seemed to comfort him. He shared stories with me about the behaviour of other patients, which he often found shocking, though he never mentioned any negative experiences with staff. In fact, he expressed sympathy for staff dealing with difficult situations.

51. On one visit, I witnessed a male patient behaving aggressively while walking towards me. It seemed like he was intending to attack me. Lee immediately intervened by pushing me into a room for safety. Staff responded quickly and removed the man. I did

not see much of the ward environment during my visits, as I would usually wait in the visiting room and then spend time with Lee outside.

52. I believe the stay gave Lee a new perspective on his mental state by exposing him to others in more severe distress, though it was clear he was still in crisis.

Care Management and Plans

53. I was not informed about any care plans involving Lee or the extent of his input in them. I believe the family's engagement was minimal and that Lee was not in the right frame of mind to make fully informed decisions on his own.

54. After Lee's discharge, there was virtually no follow-up or continuity in care. At the time, I had faith in the professionals and didn't question this, but in retrospect, I believe more support and structure were necessary.

55. I respectfully request the inquiry to obtain Lee's care plans and inpatient records from The Lakes, to determine the extent of his involvement and whether the decision to discharge him was appropriate or prematurely executed.

Treatment

56. Upon discharge, we were told Lee would be contacted within two days by another team at EPUT. No treatment plan, care plan, or follow-up arrangements were shared with us, only the assurance that we were on a waiting list.

57. At the time, I felt the treatment Lee received was acceptable due to the freedom it gave him. Looking back, I believe more intensive care, including potentially anti-psychotic medication, may have been warranted. I wish now that stronger interventions had been considered.

Safety

58. I was not aware of any abuse during his stay, although my daughter Charlie expressed concern that Lee had too much freedom, especially given his suicidal ideation and recent injury from punching the floor.

59. Lee had disclosed to us his unease around other patients whom he felt were dangerous. This, paired with his own history of self-harm and threats to take his life, raises serious questions about whether it was appropriate for him to have unrestricted movement on the ward.

60. I am unsure whether Lee was placed under any formal observations. Given his freedom to leave and his vulnerable state, I doubt he was. I request the inquiry obtain his inpatient observation records to understand what monitoring, if any, took place.

Leave, Absconsion and Awol patients

61. During his admission, Lee went on leave most evenings, accompanied by me, his sister, or a friend. These outings lasted a few hours and included meals.

62. On 5 June, Lee requested to stay overnight at home. I took him home around 5pm, and he returned to The Lakes the next morning.

63. While I don't have major concerns about how leave was granted, I feel it was too lenient given his mental state and previous threats. EPUT should have approached this with more caution.

Discharge and Continuity and Treatment in the Community

Lee's discharge

64. We were notified of Lee's discharge on 5 June without prior notice. I am unaware of any formal discharge plan. The RCA (page 82) notes that no psychological therapy arrangements were documented, and that Lee was referred to SMHT for follow-up within 48 hours and again at 7 days.

65. We were given no detailed information about post-discharge plans. Lee received some leaflets and was told someone would contact him. I was left to care for him without guidance or support. According to the RCA, a Care Coordinator was never appointed at the time of either admission or discharge.

66. Lee was discharged on 6 June 2019, reportedly at his own request. As his family, we had no say in this decision. I recall only that Dr [redacted] informed me about the EUPD diagnosis. I do not know how much input Lee had in planning his after-care.

Concerns About Discharge and Lack of Follow-Up

67. I am deeply concerned about the decision to discharge Lee and the processes that followed. I urge the Inquiry to fully investigate these aspects.

68. I respectfully request the Inquiry to obtain Lee's complete medical records from EPUT to allow for a full and accurate account of his care. After the inquest into Lee's death, I was informed the coroner had accepted EPUT's explanation in lieu of a full report due to the COVID-19 lockdown. I believe this has left key issues unexplored.

69. Without access to Lee's full records, I am limited in my ability to present the complete picture of the failings in his care.

70. According to the RCA, Lee did not receive his 48-hour follow-up in time. Attempts were made on 10 June, which was four days late. This alone reflects a serious breach in duty of care.

71. Lee also missed an appointment scheduled for 12 June, and again on 19 June, but there is no evidence that appointment letters were ever sent to him.

72. The only letter on record was a draft containing the wrong hospital number. Lee was never told about these appointments, and I never saw any letters.

73. Missing two appointments in such a short period should have triggered concern. It appears no meaningful action was taken.

74. On 12 June, Gosfield Ward told me they were trying to reach Lee. I explained his phone had been sent away for repair, and that he had multiple numbers. They also had my number and his consent to contact me, but I was never called.

75. I raised my concerns during this call and was told they would contact Lee the following day and notify SMHT. However, the RCA confirms no email was ever sent

76. This lack of follow-up was unacceptable. The professionals failed to carry out even the most basic tasks required to safeguard Lee.

77. Between 13 June and 7 August, I was not contacted by anyone from Gosfield Ward or SMHT.

78. On 7 August, concerned by Lee's continued lack of treatment and support, I contacted SMHT and expressed my frustration. I was told they had spoken to Lee, but Lee didn't even know I had been calling. I had been shielding him from further disappointment, which I knew would impact his EUPD.

Engagement

79. Up until his discharge from The Lakes, Lee was kept fully informed about decisions concerning his care. However, once discharged, all communication ceased. There was no contact from either the Mid and South Essex Partnership Trust or EPUT. Although Lee had provided consent for me to be involved and to discuss his care, we were given no further involvement whatsoever.

80. Following his discharge, the Community Mental Health Team should have maintained contact with Lee and, where appropriate, with me. Unfortunately, there was complete silence. As I mentioned earlier in my statement, on 7 August, I called the SMHT again to ask for an update. By that point, two months had passed, and no steps had been taken to provide Lee with any follow-up care or treatment. I was told, once again, that there was a waiting list for a care coordinator. I made it clear that this was not an acceptable excuse. At that time, I could see that Lee's mental health was deteriorating, and yet, despite his consent, I was repeatedly met with, "*We can't discuss Lee's care with you.*"

81. While I have no concerns about the engagement from staff while Lee was an inpatient at The Lakes, I have significant concerns about the complete breakdown in communication following his discharge. As previously outlined, the lack of involvement and support was deeply troubling.

Concerns and Complaints: Quality, Timeliness, Openness and Adequacy of Responses

Inpatient Care at The Lakes

82. During Lee's time as an inpatient, I was not informed about how to raise concerns regarding his safety or that of other patients. That said, I did not raise any formal or informal complaints during this period regarding his care.

Outpatient Care in the Community

83. I consistently raised the issue of the delay in referral for treatment following Lee's diagnosis of Emotionally Unstable Personality Disorder (EUPD) and its effect on his deteriorating mental health. Each time I called to follow up on when he would be allocated a care coordinator or receive the necessary treatment, I was met with excuses about waiting lists. Despite assurances that my concerns would be followed up, I do not believe they ever were.

84. I do not believe that any meaningful or credible action was taken in response to the concerns I raised. Those responsible for Lee's care failed to act with the urgency and seriousness required.
85. I strongly believe that my repeated complaints about the delay in Lee's care were not treated with the importance they deserved. There seemed to be no real commitment to ensuring Lee received support or follow-up care, no urgency in allocating a care coordinator, and no consistent effort to keep Lee and/or us, informed.

Events Surrounding Lee's Death

86. In the days leading up to Lee's death, things between us had started to improve. He had been staying with a work friend while the friend's parents were away. They were off work, riding quad bikes, and relaxing. Lee returned home on Thursday 22 August.

87. On Friday the 23rd, we invited him out for lunch, but he declined, saying he didn't feel up to it. That weekend, with Gary's family visiting, Lee kept mostly to himself, again saying he didn't feel well.

88. On Sunday, 25 August, Lee went for a meal with his sister. He seemed lighter in mood when he returned, telling me they'd had a good conversation and managed to clear the air after a difficult year.

89. On Monday, 26 August, it was just the two of us at home. I invited him several times to join me in the garden, but he said he just wanted to relax in his room. Later, he went

out on his bike, likely to smoke, as I didn't allow it in the house. When he returned, I noticed he seemed subdued and deep in thought.

90. That evening, I made him dinner, which he said he'd eat later. Around 9 p.m., he said he was going to bed as he had work early the next day. When I asked if he was looking forward to going back to work, he said yes.

91. On the morning of 27 August, I woke at 6 a.m. and checked Lee's room, as I usually did, to see if he had gone to work. His bed was empty. The back door was locked, which was unusual, and the front door was still bolted. His work bag was still in his room. I called him repeatedly and then called his friend from work. When I finally got a response, it was not Lee but a police officer.

92. The officer asked where I was and said he would come to my house. When he arrived, he told me that Lee had been found in **woods.** He then showed me a photo of a note Lee had left at the scene. It said he was sorry and that he was happy now. I was asked if I wanted to identify the body, but I said no, I didn't want that to be my last memory of him.

93. I don't recall much of what happened next. My husband and children came home straight away and took over the practical matters. I was supported by them through those unbearable early days.

94. On 28 August, we went to Colchester Hospital to identify Lee. My son and ex-husband went into the room. On the way home, I called EPUT's Mental Health Team and told them they could take Lee off their books and that we had just identified his body. I told them this was a failure on their part. Later, I received a condolence call from a manager. I cannot recall my exact response but everything was a blur.

95. At the time, no one properly explained what formal processes would follow. We were left in the dark, trying to navigate our grief without any structured support or guidance.

96. Aside from the support of my family, we were not offered anything meaningful in the immediate aftermath. If any support was offered, it was not clear or effective. The damage had already been done.

97. The way I was informed of Lee's death was extremely distressing. Being shown a photo of the note was, to me, harsh and sudden. After identifying his body, we were left to cope alone. There was no aftercare, no follow-up support, no communication to help us understand what would happen next. It felt like the system failed Lee and us.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

98. On 29 August 2019, I received a letter from EPUT informing me they would be investigating Lee's care and liaising with the Coroner's office.

99. On 17 September 2019, a similar letter was sent under the Duty of Candour, offering me an opportunity to contribute. I did not have direct contact with the Family Liaison Officer or participate in the root cause analysis investigation.

100. On 13 November 2019, I received an update stating the investigation report was nearing completion and asking if I wanted a copy.

101. On 8 January 2020, I received the root cause analysis report, dated October 2019. It arrived just before the inquest. I tried to read it and made notes, but I couldn't fully take it in due to the timing and emotional distress.

102. After the inquest, I agreed to meet with EPUT on 10 February 2020 in Colchester to discuss the report.

103. During that meeting, I asked why they didn't try to contact me when they couldn't reach Lee, since he had given consent. I also questioned the missing appointment letters and why I wasn't informed of his missed appointments.

104. On 14 February 2020, EPUT responded, stating they couldn't confirm which phone number they used and admitted the letter had the wrong hospital number and may never have been sent. When clearing Lee's room, we found no such letter, despite finding other correspondence like bank statements and payslips.

105. Due to the pandemic, it was difficult to contact the Coroner's office. In July 2020, I was informed that the Coroner was satisfied with EPUT's response outlining a new *"post inpatient discharge process"* including 48-hour face-to-face follow-up and improved discharge planning.

Concerns Raised During Inquest and EPUT's Findings

106. During the inquest, I raised concerns about the lack of care Lee received after discharge. EPUT acknowledged multiple failings in their investigation.

107. EPUT's root cause analysis identified numerous failings, including:

108. • Delayed and inadequate follow-up.
109. • Poor communication and documentation.
110. • Failure to follow disengagement policy.
111. • Lack of family involvement despite consent.
112. • Lessons not implemented in real time.

My views / reflections

113. I agree with the findings in the Root Cause Analysis report and believe they demonstrate systemic failures that contributed to Lee's death.

114. I had no concerns about Lee's inpatient treatment. He was treated with care and respect.

115. In hindsight, I am troubled that Lee was never assessed for ADHD. My daughter, who began studying psychology after Lee's death, believes this may have helped him receive more appropriate care.

116. If EPUT had followed its own policy, Lee would still be alive. He was willing to engage and hopeful. That hope was taken from him.

Recommendations for Change

117. My family and I feel severely let down by EPUT. Lee believed, briefly, that someone cared, but that belief was shattered when no follow-up came. It broke him.

118. Had Lee been kept informed, had he understood the reason for delays, had he been told he was a priority, I truly believe he would have been okay. But instead, he was ignored.

119. We urge the Chair and Government to implement the following:

120. • Recruit more medical professionals and support staff.
121. • Implement a more robust and accurate recording system.
122. • Improve training for community mental health staff.
123. • Ensure better communication with next of kin and greater involvement in care planning.
124. • Improve communication with patients.
125. • Strengthen and enforce discharge follow-up procedures.

Statement of Truth

I believe that the facts stated in this Rule 9 Witness Statement are true.

Signed: **[I/S]**

Full Name: Carole Stokes

Dated: 07/05/2025

List of Documents

I attach the following list of documents

1. Record of inquest dated 4th February 2020
2. Inquest bundle touching upon the death of Lee Henry Spencer dated 28th January 2020, which contains but not limited to:
    a. Post Mortem Report (Pathologist, Dr [I/S]) dated 4th September 2019
    b. Post Mortem Supplementary Report (Pathologist, Dr [I/S]) dated 7th November 2019
    c. GP Report (GP, Dr [I/S]) dated 15th November 2019
    d. GP Summary (Coggeshall Surgery)
    e. My life letter dated 17th October 2019
    f. Root Cause Analysis Report (EPUT) dated October 2019