WITNESS STATEMENT OF ROBERT WADE PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1) I, ROBERT WADE [I/S] of [I/S] [I/S] am the father of the late Richard Wade (born on 13/04/1985 and died on 21/05/2015) WILL SAY AS FOLLOWS: -

2) I am making this statement based on my memory of events, from my understanding of my late son's records / other disclosure and the evidence placed before the inquest (into my son's death).

Diagnosis

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

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

5) A private appointment was made for Richard to see a leading MND specialist, who confirmed that Richard did not have MND. The doctor, having delivered his conclusion, said: *"But you won't believe me, will you?"*

6) Richard's simple reply was: *"No."*

7) Comment(s):

   i. Each of the medical professionals with whom Richard consulted at this time gave him appropriate treatment and care within their compass. What seemed to be missing was any route to specialist resources to hasten Richard's recovery.

8) Following the aforementioned home visit Richard's condition gradually deteriorated. He was too ill to work and so we kept him home, always in the company of one of his immediate or close relatives and friends.

9) Richard's deterioration continued for some time and then reached a crisis point in mid-summer 2007, when the intensity of his symptoms accelerated. His anxieties grew to fully occupy his mind, and no degree of reassurance could calm him. At this point a home GP appointment was made. After assessing and diagnosing his patient, and consulting with his family, the doctor administered a strong sedative and Richard slept heavily. Richard continued to sleep heavily for some weeks, always with at least one person for company.

10) As Richard recovered his sleep, his anxieties diminished. This was aided by a course of private counselling until he was ready to pick up the threads of his life. Returning to education and academia he studied an MA in History and a PhD in Political Science at Essex University.

11) While attending Essex University Richard:

i. Founded an academic student journal, taking it through to publication including his own research;

ii. Founded, recruited, trained and led a debating society and team;

iii. Played for the university rugby club; and

iv. Supplemented his income by lecturing in American Politics.

14) On completion of his studies, he authored and had published a book on British politics. He then joined a major city accounting consultancy and began to study for his professional qualifications.

15) Comment(s):

i. We do not question the long-term treatment of Richard's illness by antidepressants, rather we note that they addressed the *chronic* aspects of his condition. It was the sedative Richard received from the GP's home visit that addressed the *acute* side and opened the way for his more rapid recovery.

16) The years between his two bouts of mental illness were the most productive of his life.

17) Through early May 2015 we accompanied Richard on several consultations, that were:

i. Monday 4 May - when at home Richard's fear of MND first reappears and he attends an out-of-hours clinic in Braintree, the GP prescribes diazepam

ii. Tuesday 5 May - Local GP [Sudbury], sleeping tablets

iii. Thursday 7 May - Beauchamp Surgery [Richard's GP, Chelmsford], initial blood test request

iv. Sunday 10 May - Broomfield Hospital A&E [Chelmsford], blood test requests added

v. Monday 11 May - Broom field Hospital, blood tests

vi. Tuesday 12 May - Beauchamp Surgery, sleeping pills & anti-depressants

vii. Richard's next contact with medical professionals was the Suffolk mental health crisis team at our home on the evening of 16 May 2015. Details of this contact are given in our reply to Question 8.

18) Comment(s):

i. Through the course of these visits the terms anxiety and depression were used interchangeably.

ii. Again, the chronic symptoms were being treated by antidepressants but this time some thought was given to the acute, being treated by sleeping tablets despite these having almost no effect on Richard.

iii. No treatment path, apart from pills, appears to have been considered.

Assessment

19) Apart from that of the Suffolk crisis team, Richard was not subject to any other detailed mental health assessment for inpatient care.

20) Never in all the consultations that took place was there ever mention of Richard being in danger, no useful advice on what to expect and never a conversation about possible more specialist interventions.

21) There were no other such assessments.

22) Our recollections of the evening of 16 May are:

i. Richard's condition had been deteriorating for some two weeks and despite constant care he could only find temporary relief. On the evening of Saturday16 May Richard was assessed by **MHA**, the emergency mental health assessor on behalf of Norfolk & Suffolk Partnership Trust.

ii. Richard had been pacing for much of that day constantly trying to reassure himself with regards to his anxieties and fear of MND. Despite our best efforts during that day there was nothing we could do to help him.

iii. Dinner was prepared late that afternoon and when we sat down Richard did not respond. We found that he was outside the house and despite my best efforts to convince him otherwise he refused to re-enter our home. At this time Richard hinted that there might be a violent outcome to the conversation. I withdrew indoors to discuss our exchange with my wife.

iv. We called our other son earlier that afternoon to let him know of his brother's worsening condition. He now returned and having tried to talk to Richard commented "*the man I met was not my brother.*"

v. From the house we could see that Richard was at a neighbour's house talking to the resident. We talked through our situation and that of Richard and concluded that unless he was willing to re-enter the house, which he was not, there was little to nothing more we could do for him.

vi. Although we determined to contact the mental health service, our intention was overtaken by events when an emergency assessment team arrived. The team consisted of a nurse and two police officers.

vii. Richard's assessment was carried out in the street outside our home by the Suffolk crisis team nurse, **MHA**

viii. None of Richard's family attended his assessment; we were neither informed nor invited. The two police officers were in close proximity, but they made no comment about the

assessment throughout the evening. We were involved in discussions about the background to Richard's illness and how things should progress, but the decision to take Richard into a mental health facility care had already been taken.

ix. We do not know what was covered during the assessment, only what was discussed afterwards.

x. In discussion with **MHA** it became clear that Richard's mental condition was deteriorating, and he was in a state of truly heightened stress and anxiety. His fear of MND was considered delusional and possibly psychotic. **MHA** commented that Richard might be *"on the spectrum",* meaning autistic. This was somewhat baffling to us given his interests, wide circle of friends and regular visits to Premiership football stadiums.

xi. During our discussion with **MHA** we were asked for and gave all the relevant information we could. We covered Richard's personal history, the events of his first and, this the second, bouts of mental illness, his recent behaviour and the issue of suicide. We further described his irrational fear of MND and his long involvement with the MND Society following his first illness. We covered his personal history, academic history, interests and lifestyle. Nothing was left out.

xii. The only next step of which we were aware, after a bed in a mental health ward had been secured, was that he would be admitted onto a ward.

xiii. Our one concern was his safety, and my wife asked **MHA**: "*will he be safe?"*

xiv. Her reply: *"Yes."*

xv. Following discussion with **MHA** it was agreed that Richard needed to be admitted to a secure accommodation for his own safety, as suicide had already been mentioned and needed to be accounted for, especially given his acute condition.

xvi. The nature of his admission - whether it should be voluntary or under section of the MHA was also discussed. Great thought was given to Richard's future and the difference in consequences for the two types of entry; having been reassured that Richard would receive the same care whichever entry route was chosen, and Richard being in a desperate state, voluntary admission seemed the best solution.

xvii. The next step was for Richard to be taken to The Linden Centre in Chelmsford, and the Police together with **MHA** were to take him there for admission, which they did.

23) Although we have no concerns about the manner in which the assessing nurse conducted herself, we do have two major concerns regarding our experiences during the crisis team visit:

24) From their arrival in the late afternoon until their departure before midnight, Richard was kept outside for several hours, and as the temperatures dropped and the time passed, requiring tea, food, and warm clothing to be sent out to keep the cold at bay.

25) The nurse's assessment of Richard and discussions with family accounted for a fraction of that time, and the need for Richard to be in safe accommodation had been identified on completion of his assessment. The remainder of the time was spent trying to have Richard accepted into a hospital.

26) The problem appeared to be that although Richard was at the family home in Suffolk, his GP was located in Chelmsford, Essex. When Norfolk & Suffolk Hospital Trust realised that Richard's GP and personal home were located in NEPT's area of responsibility they wanted him to be taken there, NEPT took the opposite view.

27) Throughout all this time, Richard walked the street accompanied by a police officer. The situation was resolved when MHA was given a private number of someone within NEPT.

28) At some point during the evening Richard accused me of intending to kill him. This he told to the police and after MHA had identified the possibility that he was delusional.

29) This accusation was then abruptly and accusatorially presented to me. Given the way in which this was done, and openly in the hallway for all to hear, it came as a thunderous shock to me. Making matters worse for me was that the front doorway was open and I could see Richard looking back with the stress and fear of his circumstance, etched on his face.

30) The questioning quickly ended, as there was nothing to answer for. But the consequences did not end there:

i. It made it next to impossible for me to fully participate in identifying the best course of action for Richard;

ii. It increased the heavy burden already carried by my wife; and

iii. Prevented me from saying goodbye to my son.

31) *Comment(s):*

i. Why was Richard not simply taken to the nearest available and most appropriate facility? Any transferable cost implications between Trusts could have been resolved later, once the acute situation had been managed.

ii. A degree of sensitivity on the part of the police would have not only been appreciated but would have assisted enormously in not making a very difficult situation any worse than it needed to be.

Admission:

32) It is correct that 2015 was Richard's first admission to a Mental Health ward.

i. MHA made the decision in discussion with us; we do not know who it was within NEPT that approved Richard's admission.

ii. The admission was informal.

iii. We did discuss an admission under section but chose an informal one, following advice from MHA - that advice and assurance being that Richard would receive the same standard of care irrespective of admission type and protect Richard's long term career prospects.

iv. Richard was accepted for admission by NEPT at approximately 11pm, arrived for admission procedure at 12pm, and entered the ward at 1am.

v. Richard was admitted to Finchingfield Ward.

33) The admitting nurse at NEPT, Stf Nrs 1, refused to accept MHA oral statement. MHA refused to type in all her handwritten notes to NEPT's records system. I was told this by DI during his Corporate Manslaughter investigations, and it is also in the statements and SIIR transcripts of Stf Nrs 1

34) We knew and told MHA of Richard's suicidal ideation; Richard told the assessing doctor of that ideation; it is in his records; suicide was a factor recorded on his admission record.

35) The doctor who performed the medical assessment was a locum and not a full member of the Institute of Psychiatry - he was an Associate.

36) The search of Richard's possessions was cursory at best; leaving Richard, known to have suicidal ideation, with shoelaces, electric cords, razors, scissors and his dressing gown cord (with which he took his life).

37)This search was found to be inadequate at Richard's Inquest, forming the basis for a 'Prevention of Future Deaths' instruction to the Trust by the Coroner.

38) *Comments(s):*

i. Whatever the rights and wrongs of the disagreements between **Stf Nrs 1** and **MHA** it is of huge concern that their professional focus was not on prioritising the immediate and urgent needs of a suicidal and potentially delusional patient.

ii. Throughout all the medical consultations in 2015, not one doctor ever discussed admission. Indeed, despite some showing clear concern for Richard they all appeared unable to do anything other than prescribe anti-depressants and occasionally sleeping pills.

Ward Environment

39) At midday on 17 May 2015 my wife and I were met by **HCA 1** a health care assistant, at the entrance to The Linden Centre. He claimed to recognise us as Richard's parents.

40) Personal identification was neither requested nor shown. We were neither asked to sign the visitors' register nor did we do so.

41) We were then invited onto Finchingfield Ward and led onto that ward. HCA 1 then left us there unattended, and unknown to any member of staff or patient, while he searched for Richard.

42) We were at liberty to walk off, enter rooms and interact with patients - there was no-one there to stop us.

43) HCA 1 made bizarre claims that a doctor was soon to see Richard for release (given that he had entered not 12 hours before and his suicidal nature this was baffling). HCA 1 also told us that Richard had had a good night which we found very hard to believe in the circumstances.

44) It was apparent that HCA 1 had not a clue where Richard was as he was walking about asking all if they'd seen Richard. Given the circumstances that had led to Richard's admission, we found this extremely worrying were growing more anxious with each passing minute.

45) All the staff were dressed in everyday clothes making it impossible to identify them, and making it possible for anyone, patient or visitor, to impersonate them

46) On 5 August 2015 we met with DDN (Deputy Director Nursing, NEPT), OpDir (Operations Director, Linden Centre) and Chg Nrs (Charge Nurse, Linden Centre). DDN was of the opinion that it was appropriate for Richard to keep his dressing gown cord in the name of dignity, I pointed out that there was no dignity in dying by self-strangulation on a toilet floor. DDN also seemed confused when, in response to her citing the removal of ligature points, I pointed out that the common factor in strangulations was the ligature, not the point of suspension.

47) I understand that at that time the Trust had no ligature policy.

48) *Comment(s):*

i. I believe that our names were entered into the visitors' log, but not by us.

Staffing Arrangements, Training and Support

49) None of the staff were in uniform, therefore it was impossible to tell who they were and how many were on duty.

i. After Richard's discovery, we were left waiting in the family room, we did not know who to ask for information about his condition.

ii. The desperation of knowing something serious had happened and was happening to our son just some 50 yards away and not being able to get information was horrendous.

50) With respect to staff training and based on our observations on 17th May 2017, our concerns fall into three categories -

i. Security: The Linden Centre housed many vulnerable adults to all of whom the Trust owed a duty of care for their safety and security. It should, therefore, be obvious that careful control and record keeping of those entering and leaving the building is an essential element of security. And yet when we entered the building we were neither asked for identification nor required to register our visit. In addition, and during an emergency situation, our son was able to enter unchallenged and unnoticed by following another entrant.

ii. Safety: We were taken straight to meet Richard, despite the fact that the previous day, Richard was delusional and believed that I wanted to kill him.

iii. Training: throughout the time that we occupied the family room, and during emergency conditions, the main entrance was not manned. At one point a paramedic with an oxygen cylinder was unable to enter until I demanded a member of staff that the paramedic be

admitted. Throughout the emergency there was an air of panic, and this is reflected in the SIIR. It gave the appearance of the unpreparedness that comes from the lack of exercises and drills necessary to an effective emergency response

51) Ability -

i. The witness statement of the on-call Dr/paramedic states that the paddles of the defibrillator were on the wrong way, meaning that the initial attempts to restart Richard's heart (he was in cardiac arrest) served no purpose and some of the most valuable recovery time lost.

52) Our third concern is staff conduct –

i. On Sunday 17 March we arrived at the Linden Centre at 11.50. No staff were visible, so we rang the bell. Nobody answered, so we rang the bell again. A member of staff opened the door and allowed us to enter. The time was around 12.00.

53) HCA 1 saying that he recognised us because we looked like Richard. This we found surprising, and especially so as HCA 1 requested no proof of identification and did not require us to complete any type of visitor's log of entry.

54) Being taken by HCA 1 directly onto the ward where Richard was roomed. This was an even greater surprise given Richard's accusation the previous evening and we were sure that that information would have been relayed to the facility's staff.

55) HCA 1 continued with further unsolicited and puzzling statements:

i. That Richard had had a good night - and this despite the strange environment and having barely slept for weeks despite using sleeping tablets;

ii. That Richard had been administered Fluoxetine the night before - Richard had been prescribed Sertraline during his GP visits;

iii. That Richard was to be assessed for release that day - which we found astonishing given that just 12 hours previous Richard had been admitted for being suicidal, delusional, still fearful of MND, sleep deprived and having had an acute stress reaction;

iv. We were also told by HCA 1 that he had seen Richard 10 minutes before and was on quarter hourly checks.

56) We were placed beyond the last set of doors leading to Ricard's bedroom and looking directly at the bathroom door behind which Richard was to be found.

57) HCA 1 went on to Richard's room on the right-hand side at the end of the corridor. Richard was not there, and so HCA 1 walked back past us saying he would look in the garden. Coming back again, HCA 1 asked what we assumed to be other members of staff if they had seen Richard, and for what seemed several minutes, these in turn walked about asking about Richard's whereabouts.

58) A shout went up that, *"He's in the shower!".* Looking back, we could see Richard lying on the floor and then the alarm was raised. Within 30 seconds we were sent back to the family room near reception.

59) As we left for the family room we were passed by Wrd Mngr and Stf Nrs 2 both running towards the bathroom. Their passing us at that time raises serious issues.

60) Once in the family room we were for the most part left alone but witnessed some troubling events:

i. A squabble between staff and visitors

ii. Our second son entering without challenge or record

iii. A paramedic with an oxygen bottle unable to re-enter the ward because no staff were available to open the door

61) Our interactions with staff, and there were few, were uninformative and one troubling.

62) We were told a senior member of staff would come to report to us what had happened to Richard. When the senior member of staff arrived, he kept his eyes and face hidden from us and spoke in a bizarre and indecipherable Eastern European / Italian accent. The only words we understood were choke and cord, and our requests for repetition were ignored. It transpired that this 'senior nurse' was [I/S] a bank care assistant.

63) We were then moved to seats in a corridor. In what must have been over half an hour we were briefly checked on perhaps twice; no meaningful information was imparted. We were then informed that Richard had already been taken to A&E.

64) On our arrival at A&E we were directed to their family waiting room. There was already two women sat separately. After a brief period one of the women recognised our plight and courteously excused herself. The other remained and sat in a formal pose.

65) As we as a family tried to grasp what happened we noted that the remaining woman was paying close attention to our conversation. We challenged her and she stated that she was from the Trust.

66) We tried to get what information we could from her but little of use was forthcoming. What we did get was that Richard had been a charming man, interested in the other patients and their treatments and endeared staff with his slightly shy manner.

67) The next piece of information was the most shocking. Not only did HCA 2 inform us that Richard had choked himself using a cord, but she also demonstrated it.

68) An A&E doctor informed us about the seriousness of Richard's condition and asked a few questions. HCA 2 left and shortly after Richard was transferred to ICU.

69) At ICU the full extent of Richard's injuries was revealed to us. The extent of those injuries was such that they provoked a senior ICU Charge Nurse to issue a Safeguarding report for the first time in his career.

Care Management and Plans

70) An undated and unsigned care plan was shown to us but as far as we are aware, Richard was not involved in its creation. The Trust claiming that he was "too compliant". Given events, there was no opportunity for our involvement. The third page of the plan, where the writer's signature should have been, emerged some weeks after the main content. It too had no signature.

71) As far as we can determine Richard had no meaningful involvement of any kind with any staff members. Nothing was recorded but minimal comments on observation sheets, and just the one that was in character, when he asked to have a shower.

72) As far as can be determined the only person involved in writing Richard's care plan was its author, and due to there being no signature that author remains unknown to us.

73) My wife had to call the Linden Centre early in the morning of 17th May to find out about Richard's condition as no one had called us.

Treatment

74) In 2015 GPs prescribed Sertraline as an antidepressant and a short course of sleeping pills to help him sleep.

75) Apart from prescription drugs, Richard received no treatment resulting from his visits to GPs and A&E departments

i. N/a

ii. N/a

iii. N/a

iv. Richard's diagnosis did not change.

v. His medications did not change, his treatment did not change but his condition continued to deteriorate, accelerating over the weeks immediately preceding his admission to The Linden Centre

76) There were many parallels between the two bouts of Richard's mental illness (2007 & 2015):

i. The hidden build-up to a 'pre-crisis';

ii. A 'pre-crisis' period during which Richard expressed his fear of MND, his loss of sleep, a constant need for reassurance but a gradual increase in the severity in his symptoms and anxiety; repeated visits to GPs and A&E, antidepressants and sleeping tablets being prescribed, leading to…

iii. A rapid deterioration in his symptoms leading to a crisis in which his irrational fear of MND overwhelmed him, leading to constant vocalised self-reassurance and pacing

77) His two experiences meaningfully differed only in the actions taken once he was in crisis. In 2007/8 we arranged for a home visit by a GP, who administered a heavy dose of sedatives which put Richard to sleep, after which Richard was on a path to recovery. This was the only effective intervention in his suffering.

78) In 2015 as previously explained, the emergency team spent hours securing an admission for Richard, after which he was taken to The Linden Centre where he was to take his life.

79) Richard was prescribed Sertraline by his GP but administered Fluoxetine on Finchingfield Ward.

80) The SIIR witness statements mention that Richard was not given a sleeping tablet on admission to the ward because he may have slept through breakfast later in the morning. Given that Richard was admitted in crisis, and underpinning that crisis was in part was his sleeplessness, I do not understand why not missing breakfast was prioritised over Richard getting the rest he needed.

81) In relation to the Linden Centre in so far as the first paragraph of the above response applies. Richard did not live long enough for any incorrect medication to become an issue.

Individual Circumstances and Characteristics

83) Richard was in excellent physical health on admission to the Linden Centre. It was his mental health that was the problem; the recurrence of his irrational fear of MND with its attendant loss of sleep, anxiety and suicidal thoughts were the problem.

84) Beyond Richard's fear of MND and its attendant symptoms he suffered no other mental health difficulties. After her assessment of Richard on the evening of 16 May **MHA** did express a view that Richard may be *"on the spectrum"*. This had never arisen in 30 years and in my view (shared by my wife) was a misunderstanding of Richard. Richard was by any measure extremely intelligent and may have been perceived as "different" on a first acquaintance, but he was not autistic.

85) On 16 May I gave MHA a warning that if Richard became overwhelmed by his suicidal ideations and there was a flaw in the safety policies and procedures in a ward, he would quickly identify it.

86) That warning does not appear anywhere within the documents I have received relating to the Trust and so I can only surmise that this information did not reach the ward.

87) Richard's death certificate unambiguously states "*Richard's risk of suicide was not properly and adequately assessed and reviewed…"*

88) The dangers to Richard were clear:

i. He had expressed suicidal ideation to MHA;

ii. MHA was aware that Richard was more than capable of finding flaws in the procedures designed to keep him safe (I shall address the flaws in the procedures later);

iii. Those policies required stated new patients with suicidal ideation should receive 1:1 observation until safe not to;

iv. That Richard was experiencing suicidal ideation was passed on to NEPT at his assessment and written into his records

89) It is my opinion NEPT should have taken a more protective approach to Richard's care, as directed by its own policies:

i. Immediately placed Richard under 1:1 observations: … *(Management of Suicidal Service Users Policy: Para. 7.2.3 Identification of Service Users at IMMEDIATE Risk of Suicide [Trust's capitalisation])*

ii. After reception on the ward, the senior nursing staff should as a minimum have kept closer, not cursory, eye on Richard: … *(In-Patient Observation and Engagement Policy: Para. 4.13 High Risk Periods / 4.13.1 bullets 1 & 2 and Management of Suicidal Service Users Policy: Sub-paras. 4.4 & 4.8)*

iii. Having seen the suicidal ideation on his records they should have upgraded his observations to 1:1. *(Management of Suicidal Service Users Policy: Para. 3.7 In-Patient Observation Levels Related to Assessed Level of Risk)*

90) Richard would have been helped through his crisis and survived, and with proper care and guidance have found a way to live a fruitful life

91) The above exhibits three major failings on the part of NEPT:

i. The absence of open and sincere communication leading to the missing of vital patient information

ii. A minimalist interpretation of the risks identified in the information

iii. A willingness to breach policy

92) Item 1 left Richard unprotected from the motive for his suicide; 2 amply provided the opportunity for Richard's suicide; and 3 the means.

93) When Richard entered The Linden Centre, his luggage was searched for dangerous items. He was left with razor blades, scissors, shoelaces and his dressing gown cord. Deodorant spray was confiscated.

Safety

94) We had no immediate concerns on the evening of 16 May beyond what would expect for a son and brother; we were too exhausted and needed sleep for the coming day. It was due to the lack of information from and response to my wife's call to the Linden Centre that we started to have doubts about the Linden Centre. An internet search on the morning of 17 May revealed many poor reports and serous concerns regarding safety and treatment, and so we formulated a plan to move Richard to a safer location.

95) The plan was that my wife and I would drive to the Linden Centre and re-establish communications with Richard, and given the events of the previous evening, possibly with me waiting in my car. Our son would drive to Richard's flat to retrieve details of his private health insurance and then meet up with us and Richard.

96) Once Richard had agreed a way forward, and a new hospital found, he would have been moved to that location. Fate intervened and we were to be too late by minutes.

97) We are not aware of Richard suffering any physical abuse while on Finchingfield Ward. We are aware of the possibility of neglect.

Transfer

98) The only transfer of Richard was from the family home in Suffolk to The Linden Centre in Chelmsford on the night of 16 May. We are not aware of any incidents occurring during that journey.

Engagement

99) With regards to his assessment by Suffolk's crisis team, as Richard would not re-enter the family home the nurse completed her assessment in the street outside our home. When we discussed matters such as voluntary or section admission, Richard was consulted as far as was practicable.

100) As previously discussed, Richard was not included in the development of his care plan at the Linden Centre because he was "*too compliant*". The care plan was generic in nature with Richard's 'voice' completely absent.

101) In Suffolk, Richard's involvement seemed reasonable given the circumstances. In Chelmsford not so.

102) In addition to his absence in the care plan, other comments by staff are scarce and scant. Observation sheet comments being restricted to the barest minimum and no hint of action taken from the observation made. It is instructive to compare the comments recorded with those deemed inadequate in the guidelines to NHS Professionals.

103) The SIIR states that "… *obvious communication took place* …" despite there being no physical record. NHS guidelines on note taking state that courts of law tend to adopt the position "*if it is not recorded, it has not been done*".

104) Richard's physical health was never in question; he was and had kept himself in excellent condition since his mid-teens.

105) We were not able to make any contribution to any decision taken in respect to our son at The Linden Centre.

106) The Linden Centre at no time attempted to contact us while Richard was in their care, albeit for no more than twelve hours.

107) The sequence of calls below is taken from a contemporaneous statement:

i. Linda Wade calls 07.20-07.30 **S/Worker** answered, saying she would call back - no call received.

ii. Linda Wade called again 1-1.5 hours later, **HCA 1** answered - enquired after Richard & told he had had breakfast.

iii. Enquired about visiting hours (10.30-20.30) and should we go down

108) Given the events of 16 May and the time of Richard's departure we decided to contact him in the morning. We were told that his phone battery was drained; we have no record of him

asking to call us, neither is there any evidence of him being told that we tried to contact him. We understand that Richard did ask for a phone charger, but none was available.

Concerns and Complaints; the quality, timeliness, openness and adequacy of responses to concerns

109) We made no complaints regarding Richard's care. Before his death there was neither time nor reason; at the time of his death events occurred too quickly; and after his death we were at first recovering and afterwards involved in a sequence of investigations by various parties.

110) Richard left Suffolk late on 16 May and we arrived at The Linden Centre just before noon 17 May; there is next to no record of any interaction with Richard at The Linden Centre, let alone his making a complaint; we had but a handful of minutes between arrival and catastrophe

111) We made no complaint before Richard's death on 21 May, nor immediately after our arrival at The Linden Centre on 17 May.

112) Over the days leading up to Richard's death we were too busy caring for him to raise a complaint. The period of time in question was about two weeks. Events on 16 and 17 were so rapid there was no time to raise a complaint and little information on which to base one.

After Richards Death

113) Before Richard's death, and while he was still in ICU, I received a voicemail from the Linden Centre asking if I wanted to *'…have a chat."* Given the circumstances I did not reply. I believe we received two letters inviting us to meet between May and August, finally meeting for the first time on 5 August.

114) For us the meeting's purpose was to get a better understanding of what happened to Richard while in the Trust's care. In this respect it proved unsatisfactory as demonstrated by the Trust's minutes of the meeting and our responses to those minutes which we considered inadequate.

115) What we found out was:

i. That the Trust did not have a separate ligature policy,

ii. That patients were left with belts and cords, i.e. ligatures, for their dignity despite this being contrary to their search policy, and

iii. The Trust representatives did not know if by policy the bathroom door behind which Richard hanged himself was supposed to be kept locked or left open.

116) The meeting was attended by DDN (Deputy Director of Nursing), Chg Nrs (Charge Nurse on the 17 May) and OpDir (Operations Director, Linden Centre).

117) When Chg Nrs escorted us to the bathroom we passed through a locked door; on the other side of the door a patient was sat on the floor, to our amazement Chg Nrs stepped over her. When we entered the bathroom, we were shocked to see the pipework [I/S] repaired but not enclosed.

118) Although sat next to me for the two-hour duration of the meeting, OpDir did not disclose that he returned to the Linden Centre on the afternoon of 17 May. During that afternoon:

i. The mess as seen in the bathroom by Stf Nrs 2 was cleaned up as shown in the police scene photographs, and

ii. According to her SIIR interview transcripts, HCA 2 reported what she had heard in A&E family room.

119) We were never offered support by NEPT, or the police, during their two Corporate Manslaughter investigations. The only support we received we arranged for ourselves through charities.

120) By the time of the Independent Inquiry our need for support had been addressed.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

121) Until we met with the Trust on 5th August 2015, we were not aware of any internal investigations by the Trust or any other NHS body. We agreed to meet regularly in relation to the SIIR.

122) We received a '72-hour report' on 14 September 2015 from **I/Dir Q** Interim Associate Director of Quality. The report is dated as being completed on 20 May 2015 by **[I/S]**

123) There were two internal investigations into Richard's death:-

i. 72 Hour Report – the report made two recommendations:
   a) That in-patient bathroom doors be kept locked until required for use, and
   b) That staff receive refresher training on security checks and patient belongings

ii. Serious Incident Investigation Report (SIIR)
   a) **SIIR Auth** was its author; an external consultant named **I/Dir Q** led meetings we attended

124) At points within the SIIR we are stated as having given information when being interviewed. This is incorrect: we never agreed to be interviewed and so never agreed with any information provided as approved as part of an interview. We agreed to meet regularly and provide information to assist the SIIR.

125) SIIR Auth was presented to us as an independent healthcare specialist holding an appropriately senior post at a separate hospital. What we were not told at the outset was that the hospital at which he was employed was a part of NEPT and therefore fell under the same CEO as the Linden Centre.

126) I have profound concerns regarding almost all of the contents of the Trust's SIIR of December 2015 as demonstrated in my response in January 2016: Review of NEP Trust SI report into Richard's death.

127) Here I shall raise what I believe to be the four significant failings relating to NEPT's care of Richard:

iii. His assessment and information transfer across NEPT

iv. The searching of his property and his being left with his dressing gown cord

v. The bathroom being opened twice

vi. Richard hanged himself

128) At the beginning of the SIIR the author introduces himself as SIIR Auth Area Chief Nurse West (NEP and Panel Chair). That is to say that his reporting line concluded at the same point as that for The Linden Centre's nursing staff, the Nursing Director sitting on the board with CEO Andrew Geldard. SIIR Auth also led the staff interviews on which much of the below is based.

His assessment and information transfer across NEPT

129) Richard entered The Linden Centre at about midnight on 16-17 May. Stf Nrs 1 was the Staff Nurse that was to accept Richard as an in-patient. The handover was from MHA [I/S] the crisis team nurse who assessed Richard in Suffolk, to Stf Nrs 1

130) MHA proceeded to give a verbal handover, but this was refused by Stf Nrs 1 Across several of the witness statements it becomes clear that their professional relationship was not good, and this confirmed by a conversation with MHA of Essex Police.

131) Ultimately their differences were resolved. A paper version of the centre's assessment forms was handwritten by MHA and entered into The Linden Centre's patient data system by Stf Nrs 1 in the early hours of 17 May; a print-out of that data entry was submitted in the document bundles of the Coroner's office for Richard's inquest, and those when his prior inquest date was postponed.

132) And when pressed on whether she thought MHA handwritten notes were thorough and of the standard expected of her own colleagues, Stf Nrs 1 answered *"Yes"* four times.

133) Richard was then examined by a locum doctor, Loc Dr. His report, too, was submitted to those same bundles.

134) Following that examination a meeting was held to determine, amongst other things, the level of observations that were to be applied to Richard. The decision was level 2, i.e. four observations per hour.

135) Level 2 observations are identified by several staff as the standard level on which new patients are placed. I shall return to this point at the end of this section.

136) At 7am the night shift handed over to morning shift and that handover was led by Stf Nrs 1 [I/S]. The two oncoming Staff Nurses were Stf Nrs 2 and Stf Nrs 3 There is no mention of Loc Dr examination report, the handwritten notes left by MHA or those

entered into the patient records by Stf Nrs 1 only a scrap of paper with a telephone number on it and that the meeting between MHA and St Nrs 1 had not gone well.

137) In their interview transcripts both Stf Nrs 3 and Stf Nrs 2 describe the limited information handed over to them. And this limited information formed the basis of level 2 observations being acceptable to Stf Nrs 2 with her doing a further assessment that morning. Stf Nrs 2 stating in the transcripts of her interviews that had she known more she would have placed Richard on Level 3 observations.

138) In paragraphs 12.2.1 to 12.2.15 SIIR Auth lists the things he believed that we passed to MHA that she did not pass on to Stf Nrs 1. He said:

139) *"… Key information shared by the family and later recited during this investigation does not appear to have been noted down in the assessment, and therefore this vital information was not handed over to receiving staff at the Linden Centre."*

140) And: *"…, a missed opportunity in fully understanding Patient Z's risks at that time."*

141) The relevant documents in the Trust's possession at that time were:

i. MHA handwritten assessment in the Trust's format;
ii. Stf Nrs 1 entry of those notes on their patient record system;
iii. Stf Nrs 1 progress notes on the same system; and
iv. Loc Dr assessment.

142) Comparing those documents with SIIR Auth list of 15 missing vital pieces of information, it is clear that almost all are there, and enough to come to a different conclusion. That different conclusion comes from C/Psych

143) C/Psych was a psychiatrist commissioned by Essex Police to prepare a report into Richard's death. The report is dated 16 November 2015, and so contemporaneous with the Trust's SIIR and based on the same information, SIIR Auth was in possession of all the same documents as C/Psych Paragraph 112 of C/Psych report states: -

144) *"I think that if appropriate attention had been given to Mr Wade's risk of suicide (and it was all in the history), that there had been an appreciation that leaving a suicidal patient in possession of a ligature and checking on him only every 15 minutes, whether consistent with policy or not, represents a significant failure to mitigate the risks of suicide."*

145) In several interviews staff stated that level 2 observations are the standard for new admissions; but that would mean level 2 is assigned irrespective of risk.

146) The policy on Admission Procedure says little with regard to observations apart from (para.2.5.2) *"A full mental health assessment to be conducted by medical staff at the earliest opportunity on admission."* An assessment was done, adequate or otherwise, and decided that Richard's risk of suicide was low.

147) Paragraph 7.2.3 of the Management of Suicidal Service Users Policy is titled *'Identification of Service Users at IMMEDIATE Risk of Suicide INPATIENTS'* [their capitalisation]. It reads: -

148) *"Behaviours indicative of suicide includes marked depression, feeling of hopelessness, restlessness, anxiety, lack of concentration, odd abdominal unusual staring, evidence of tearfulness, recurrent thoughts of death, …, withdrawal, threats of extreme violence, …." [their underline]*, and continues, *"Service user articulating thoughts of suicide, …, evidence of planning in the suicide attempts e.g. internet search history."*

149) Given these descriptors and Richard's circumstance, as C/Psych says *"(…it was all in the history), …"* it would seem that Richard, far from being at low risk was at immediate risk.

150) Continuing examination of the Trust's policy documentation, which decides observation levels for new admissions is the In-Patient Observation and Engagement Policy. Paragraph 4.12 is titled Observation of newly admitted service users' reads:

151) *"All newly admitted service users will be placed on a level of observation taking into account the Service user(sic) assessed level of risk. All Service users(sic) with a current identified high risk of self-harm / suicide should be nursed on level 3 or above dependent on the severity of the assessed risk."*

152) Immediately below in section 4.13 High Risk Periods is a list of those periods in 4.13.1:

153) *"Particular vigilance should be exercised during 'high risk' times. These include:*

i. *After admission and during staff handovers*

ii. *During the early stages of recovery…"*

154) In addition to being at immediate risk of suicide, Richard also met the top two high risk periods of effecting that suicide. As Stf Nrs 2 said in her second interview: -

155) *"And if we'd been on Level 3s then he could have had the shower, and we would have been in the shower with him and then this wouldn't have happened."*

156) In paragraph 12.3 of the SIIR its author states:

157) *"It is difficult to determine that the fullness of information which is now known about Patient Z* [Richard] *from interviews with the Street Triage nurse and the family would have*

demonstrably changed the clinician's views in relation to known and assessed risks at the time of admission, and therefore would have affected the contraband items and the degree of items removed from Patient Z, and this could be seen as pure conjecture."

158) The information *"which is now known"* was known at the time of Richard's assessment by [I/S] Stf Nrs 1, MHA and Loc Dr and in sufficient detail to give a very different outcome to the low risk then determined. That was the conclusion of C/Psych and that conclusion was based on evidence that the Trust had in its possession (and afterwards) early on 17 May.

159) Given that the premise in SIIR author's argument is in error, it is necessary to question the conclusion. And that will be addressed next.

The searching of his property and his being left with his dressing gown cord

160) The cord with which Richard hanged himself was his dressing gown belt. It, and the items he needed for a stay in hospital were contained in a bag packed for him before his departure on 16 May.

161) Paragraph 12.3 of the SIIR discusses the search of Richard's bag by Nrs 1 Of this search the SIIR says:

162) *"The only item removed from Patient Z prior to his admission was an aerosol can, which formed part of a contraband list held on the inpatient wards at the Linden Centre. The written list contraband includes the following Items:*

i. *Aerosols*
ii. *Lighters*
iii. *Knives and razors*
iv. *Recording equipment*
v. *Scissors*

vi. *Illicit substances*

vii. *Phone chargers*

163) *Following Patient Z's death, a wash bag was found, which included:*

i. *A toothbrush charger*

ii. *Razor blades*

iii. *Scissors"*

164) Of the search the author comments: - "…*that there appeared to be a lack of robustness in the searching …"*

165) What Richard did have in his possession were: an aerosol, scissors, razor blades, charger cable, shoelaces, a belt and the dressing gown belt (called cord or chord in some staff statements) with which he took his life. Only the aerosol (deodorant) was confiscated.

166) In **Nrs 1's** SIIR interview transcripts he says he asked Richard to look at a list of contraband items and confirm he had none in his possession. But that list is not meant to be definitive, below the list the sign says: *"Please Note: This is not an exhaustive list"*

167) The Trust does have another sign not mentioned anywhere in the documentation; it reads:

168) *"All service users are requested to hand in the following items to a member of staff as these items are not allowed on the inpatient area during their stay.*

169) *Staff are required to secure any of the items to maintain patient safety."*

170) The fourth bullet says: - *"Anything that the person possesses that he/she intends to be used to harm themselves or others. This may include apparently innocent items e.g. …, shoelaces, rope and chord(sic),"*

171) In relation to shoelaces and cords there is now one other SIIR transcript to consider, that of **Stf Nrs 2** second interview. On page 10 the interviewer lays out the standard list of proscribed items:

i. ***Q.*** *Now on that contraband list are things like chargers, for phones, razor blades, scissors and I think, maybe aerosols.*

172) The two enter a short conversation on search procedure and then return to the contraband list on page 11 followed by:

ii. ***Q.*** *Yes. But it wouldn't routinely be cords, belts, laces? Not routinely? So if I come onto your ward, whether I'm a low risk, I wouldn't have my laces taken out of my shoes and my belt taken off me?*

iii. ***A.*** *No, no"*

iv. ***Q.*** *Or if I worried staff sufficiently they might approach me and say, "Look, we're a bit worried about you…"*

v. ***A.*** *Yes, and things like that.*

173) The policy documents give no latitude on this issue.

174) It was stated at the beginning of this section that the author wrote there was *"… a lack of robustness …"* in the search of Richard's bag. In my view it would best be described as a failure in policy, but no mention of this is made of this in the SIIR.

The bathroom door being opened twice.

175) Richard was found unconscious with a ligature round his neck in bathroom [I/S] on Finchingfield Ward plans. After describing the search for Richard, and towards the bottom of page 17, the SIIR states:

176) *"What follows is two apparently divergent accounts of what happened next. Following statements and staff interviews, there appear to be two accounts of the sequence of events thereafter, which the investigation process has been unable to clarify further despite the reinterviewing of key staff members."*

177) What follows are two scenarios, each with two members of staff arriving to find the bathroom door locked. One member of each group unlocks the door, the door is opened, and Richard is found on the floor.

178) What the SIIR author is unable to determine is which of the two groups opened the door; in his analysis there being too many events in too short a time to answer the question '*who'* opened the door.

179) The SIIR investigation ended there with a critical question unanswered. But, if it cannot be determined which of two groups opened the bathroom door because the two cases for their having done so are equally valid, then the possibility of the door being opened twice arises.

180) And when confronted by the same evidence as the SIIR's author, the jury at Richard's inquest asked that question of the Coroner. This exchange exists within the recorded evidence of the inquest, and to the best of my recollection it was:

i. Jury member: *"Does that mean that the door was opened twice?"*

ii. Coroner: *"That is what the evidence suggests."*

181) It is not possible for both groups to be correct in their having opened the door and the door only being opened once. SIIR Auth knew of the possibility of the door having been opened twice because I raised it with him, the SIIR is silent on the issue.

182) There are four key members of staff to consider, S/Worker and HCA 1 in one group, and Stf Nrs 2 and Wrd Mngr in the other. Both groups resolutely defended their positions when re-interviewed, the door was locked when the group first approached it and nobody else was in front of the group.

183) Looking to the SIIR interview transcripts for each individual it is possible to determine what each did immediately after the door was opened by their respective group and which group opened the door first. Those actions are listed below:

i. S/Worker group1: left to get 'yellow bag' and other equipment, HCA 1 remained with Richard
ii. HCA 1 group 1: could not undo ligature, ran to get ligature cutters, S/Worker remained with Richard
iii. Stf Nrs 2 group 2: attempted to rouse Richard, gave rescue breaths
iv. Wrd Mngr group 2: untied ligature, checked pulse, commenced compressions

184) My own analysis is that If HCA 1 did indeed test the ligature round Richard's neck, and that is consistent throughout his evidence, it must have been before Wrd Mngr removed it. Therefore Group 1 must have opened the door first.

185) It now follows that for group 2 to arrive at a locked door with no one in attendance, either HCA 1 [I/S] or S/Worker had locked the door and both had, contrary to their evidence, left the scene of the incident. And this consistent with Stf Nrs 2 statement when in her second interview when, after hearing the alarm and rushing towards the scene of the incident, she sees both S/Worker and HCA 1 coming towards her and away from the bathroom.

186) If true, this means that Richard was found, then left alone with a ligature round his neck and the door locked on him. Both S/Worker and HCA 1 strongly refute leaving Richard.

Richard hanged himself

187) That Richard may have hanged himself is raised in his autopsy report on page 7, 4th item of the Comments section. The pathologist's reasoning is in two parts:

i. That self-inflicted strangulations are *"very uncommon",* and

ii. The damage to the pipework [I/S] as shown in the police's scene photographs. He finishes the point suggesting that further investigation should take place.

188) These investigations were not part of either police inquiry into Corporate Manslaughter, the CQC inspection following Richard's death and scantly at Richard's Inquest where questions were met with loss of memory answers.

189) The Trust asked the Coroner that Richard's body be retained while it considered the autopsy findings, it is therefore assumed the Trust had a copy of the report.

190) In both Scenario 1 and Scenario 2 in the SIIR of Richard being found there is only mention of the ligature, never that Richard may have been suspended, partially or not, from a ligature point. The only candidate for a ligature being the open pipework [I/S]

191) But there is evidence that Richard hanged himself in the interview transcripts:

192) When about his understanding of the "whole ligature issue", Chg Nrs replied: -

193) *"My understanding was that when* [I/S] *phoned me, he had tied a ligature. That was it. From later on the pipework, but at the time I did not know that — not until well after the case."* When asked who had informed him, he said, *"I cannot recall, but it was someone who was involved in the incident."* SIIR Auth *then brought the interview to a close.*

194) Having been asked by SIIR Auth if the ligature was attached to anything and HCA 1 answering that it was not, [I/S] enquired, *"What was up with the pipe? You mentioned the pipe."* To which HCA 1 replied, *"It came off. The* [I/S] *pipe on there."*

195) The possibilities are:

i. Richard was attached to the pipework, and it broke under his weight before HCA 1 entry,

ii. HCA 1 is mistaken, and this particular recollection comes from a later point in time.

196) In 2019 I had the opportunity to converse with Stf Nrs 2 on Facebook Messenger and ask for clarification about the ligature [I/S] She stated that:

i. Wrd Mngr removed the bathrobe cord from Richard's neck

ii. She said that the shower room should be left untouched as it was evidence

iii. She told HCA 1 to stop cleaning the shower room

iv. There was a lot of debris on the shower room floor after Richard was removed, all absent from the police photographs

v. When Wrd Mngr untied the ligature from Richard's neck, *"… the* pipe *came off with the cord when* Wrd Mngr loosened it..."

vi. She told both police officers from both investigations (2015 and 2017) that Richard was attached to the pipework

197) With regards to an evidence scene, it is stated in the SIIR that after the incident his belongings were searched and further contraband items found in his wash bag. With Richard being in a shower room, it is most likely that the wash bag was in the evidence scene.

198) And in conclusion Richard did hang himself, and this is important because in February 2015, just three months before Richard, another gentleman took his own life by hanging in the very same room as Richard.

Other Investigations or Legal Proceedings

199) After Richard's death in May 2015, the Care Quality Commission (CQC) launched an investigation into NEPT. And this after it had launched an investigation in the February of 2015 into the death of a gentleman in the very same bathroom as that in which Richard hanged himself.

200) What seemed surprising was that despite the similarities in the manner of the two deaths, not least they took place in the same room, the investigation into the February death concentrated very much on the death and the ward but that for Richard's was general and across the Trust.

201) We contacted CQC and a meeting was arranged. It did not go well. And in the weeks that followed emails were sent to the CQC but with little response. This prompted us to complain directly to the CQC's CEO - what followed was both forceful and effective.

202) A small team of executives was assembled and an internal investigation launched. We were fully informed, consulted and considered throughout. What came from this was a full explanation in the first part and a comprehensive apology in the second.

203) The CQC' internal investigation benefitted from three key ingredients beyond being comprehensive: (1) openness; (2) inclusivity; and (3) sincerity.

204) To date only two other investigations have met those three prerequisites:

i. The first Corporate Manslaughter investigation by DI and;

ii. The Essex Mental Health Independent Inquiry (EMHII) led by Dr Geraldine Strathdee.

205) The outcomes of these three investigations may not have provided the answers we wanted to hear, but their outcomes had one important thing in common - they were *useful*.

206) Through the course of DI's investigation our discussions, disagreements and exchanges helped shape our understanding of Richard's case. That understanding was to prove an invaluable counterweight to our reading of the Trust's SIIR.

207) It was that understanding that helped us to convince our constituency MP, James Cartlidge, to give us the support that has proven so invaluable.

208) By publishing its forthright report and sincere apology, the CQC gave our MP the weight of material necessary to secure a debate in The Commons over Richard's case. That debate secured an Independent Inquiry into Richard's death. A full Public Inquiry was not granted for Richard on the grounds it was a single death and there was no evidence, at that time, of systemic failure at NEPT.

209) In turn that Independent Inquiry was joined by or with other cases to form the EMHII. The EMHII in failing to come to a satisfactory conclusion, ironically because of two of the very reasons for its inception, removed the two barriers placed in the way of a full Public Enquiry for Richard by the then Minister of State for mental health.

210) I hope and trust that the legacy of the Lampard Inquiry will prove similarly *useful*.

211) Turning to Q61 - The first delay we experienced in relation to Richard's Inquest was in the release of his body after autopsy. The reason for the delay was the Trust considering whether or not to request a second autopsy.

212) The second delay arose at the preliminary hearing. Two of what we considered essential witnesses were to return to their native countries on the dates set aside for the inquest; those witnesses being the doctor that attended Richard's assessment on his admission and a Staff Nurse on duty at the time of Richard's suicide.

213) We had been put to considerable financial expense in settling Richard's affairs and set about recovering those costs through a civil action. The Trust settled those costs out of Court but did so before the Inquest itself and so were not liable to those costs. We engaged a barrister to represent us at Richard's inquest at a cost approaching £20,000. And although the CEO of NEPT verbally agreed to reimburse us this was later reneged upon.

214) We have two observations regarding Richard's Inquest, one specific and one general:

i) The original inquest was to be two weeks and had a bundle of documents two inches thick. The actual inquest was scheduled for one week, but the documentation bundles had grown to four lever-arch files of three to four inches of documents each. Much information was not considered.

ii) Over the course of the twenty years addressed by the preceding independent inquiry (EMHII), some two thousand deaths qualified for investigation. Many of those deaths must have passed across Essex Coroner's desk, and as far as I am aware there is only one Coroner's office in Essex, and that's in Chelmsford. A rough calculation suggests two deaths per week, it is difficult to understand how this pattern was not noticed, and if noticed not acted upon.

215) There were two police investigations that addressed Richard's. The first began in 2015 shortly after his death, the second in 2017 immediately after his inquest.

216) 2015 - The first police investigation was undertaken by DI of Essex Police. One crime was investigated - Corporate Manslaughter.

217) Over the course of this investigation an excellent working relationship developed. Communications were by telephone, email and face-to-face meeting. Opinions were given, challenged and discussed in an open and honest way.

218) At the end of the investigation charging advice was sent to the CPS. The CPS's response did not seem to align with the facts and so was challenged. The CPS did not send its reply until immediately before Richard's inquest in 2017 and there was too little time to mount a second challenge.

219) Immediately after the Inquest a second, and much broader police investigation was announced, of which we knew nothing, and thus a second challenge to the CPS seemed redundant.

220) 2017 - The second investigation was undertaken by DCI of Kent & Essex Police. Its scope was broader in both the number of deaths it investigated and the range of crimes considered.

221) At the first of two-family meetings (July 2017) open to over 200 families the crimes to be addressed were Corporate Manslaughter, Gross Negligence Manslaughter and all other incidental crimes. The assurance to the families being that at the end of the investigation no stone was left unturned.

222) At this point the investigation differed from that of DI in one important way - there was no meaningful communication. One exception to this was in November 2017 when we were invited to meet with DS to present any documentation, we held that it might indicate non-manslaughter crimes. At that meeting DS told us that DCI had been "*called upstairs"* to explain the lack of progress in the investigation.

223) That was the only documentation ever requested and Jan/Feb of 2018, and in response to an unrelated email, my wife was informed that all investigations into non manslaughter crimes had been dropped. There is no further explanation.

224) Our second family meeting took place and was to be the conclusion of the investigation. There were to be no prosecutions.

225) We were only given a copy of the Investigation report on *exit* from the meeting and thereafter no readmission or discussion re the same was to be allowed. Another fact revealed by DCI (then Acting Superintendent) [I/S] was that charging advice had not been sent to the CPS, instead it had been sent to a barrister for assessment. No copy of that charging advice was to be provided although it might be obtained by requesting it of the barrister who might provide it for a fee.

226) The report was mostly generic in nature and lacking in detail; correctly it contained a section on Richard but none other, but that was uninformative. So that, at the end of a long investigation, we were none the wiser and nothing happened.

227) After Richard was found we witnessed one member of staff, and one member of staff only, who seemed to know what they were doing - Wrd Mngr The remainder of what we saw ranged from poor to appalling. The documentation available to us provides us with no comfort, as it displays no warmth towards Richard at his time of need.

228) The disparities in professionalism, competence and compassion between Finchingfield Ward in The Linden Centre and A&E and ICU in Broomfield Hospital, where Richard was nursed until his death, could not have been more stark.

229) After leaving our home on 16 May we never spoke to Richard again.

230) Upon Richard's arrival in ICU the Charge Nurse was so appalled by Richard's physical condition that he raised a Safeguarding Incident form. He informed us that despite all his experience in ICU this was the first time he had ever raised one.

231) While at ICU in Broomfield Hospital we discussed Richard with the Chaplain. She was surprised to hear that Richard was on Finchingfield Ward, believing it not to be the most appropriate ward for his proper care. We have never pursued this.

232) Following Richard's death, the CQC launched an investigation into NEPT. On reading the report we were surprised to see that it was a general investigation across the whole of NEPT. It was therefore broad and shallow rather than narrow and deep.

233) This was a surprise because in the February of 2015 — three months before Richard's death — another gentleman died in the same room as Richard. It seemed to us, especially given the previous death, that a narrow and focused investigation would have been appropriate.

234) We met with representatives of the CQC, the meeting was less than satisfactory to unpleasant and so we raised a complaint with the CQC. This resulted in an internal investigation ending in a lengthy and detailed explanation of CQC failings and an apology of similar length.

235) Those two documents represent the most truthful and powerful results to investigations relating to Richard yet released. The documents were so powerful that they paved the way to my Core Participant status.

236) In response to Q 68 - As things stand, we are happy with the current terms of reference.

237) Upon completion of the Kent & Essex Police Corporate Manslaughter investigation no file was submitted to the CPS. Instead, a file was submitted to an independent barrister to determine if it would be successful *if* submitted to the CPS. That file has not, to my knowledge, been seen by any of the families whose loved one(s) were part of that investigation.

238) Given the central part that systemic failure plays in Corporate Manslaughter, the file containing the conclusions to the police inquiry may very well contain evidence of value to the Lampard Inquiry.

Additional comments and concerns

239) Richard was admitted with known and recorded suicidal ideation. NEPT's policies clearly stated that suicidal patients should receive one-to-one observation. Richard did not receive this. The important question here is why not?

240) Was the locum doctor who assessed Richard sufficiently experienced in mental health practice? Although academically qualified **[I/S]**, he was not a full member of the psychiatry institute. Did he have the experience to act as a locum for admissions to ward the skills and policies of which of which would have been unfamiliar?

241) Was there friction in the acceptance and admission process leading to poor judgement? Certainly, NEPT did not want to receive Richard and only did so reluctantly, our witnessing of **MHA** difficulties in finding a location for Richard attested to that. Also, that

MHA was compelled to enter the details of her assessment onto a record system about which she knew nothing. And finally, friction at Richard's admission was a view expressed to us by [I/S]

242) Was there insufficient staffing or did the staff that were there simply not want to do 1:1 observations? Richard was placed on regular observations throughout the night, four per hour. The recording of those observations was scant, just one or two words per observation. DI [I/S] questioned HCA 1 about the reporting of observations because they looked as though they had been written in haste after the event. We were told by DI the interview was terminated when HCA 1 began to cry.

243) These, and perhaps other explanations, are not mutually exclusive.

244) Upon our arrival at the Linden Centre on 17 May, the reception was unmanned.

245) Identifying the sequence of the phases of Richard's deterioration in both episodes of his illness, it appears that the second phase or pre-crisis, was the point at which decisive intervention would have been most beneficial. And yet in the decisions and prescriptions of both GPs and A&E were ineffective in preventing the crisis phase that followed.

246) Recognising that the visits to A&E were a consequence of the inadequate outcomes at GP surgeries, it would seem sensible to concentrate on the latter. On a daily basis, for physical health, all GPs filter their patients for referrals to consultants and specialists; and where immediate action is required emergency appointments can be sought. And although resources may be finite, rescheduling can deliver capacity to the point of need.

247) But for mental health, certainly in the case of Richard, the routes for prompt escalation either did not exist or were not used. His progression into crisis was inevitable.

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

249) Giving thought to both his long-term and short-term needs during his pre-crisis periods two distinct paths present themselves:

i. Chronic needs - at the beginning of both bouts of illness Richard was prescribed antidepressants, having survived his crisis on the first bout those drugs helped him towards his recovery, and there is no reason to doubt that would have been true for his second bout; and

ii. Acute needs - in both 2007 and 2015 nothing was either available or offered to prevent Richard's progression into crisis

Recommendations for Change

These will be presented as a separate document.

Documents which I have:

Please see Appendix A

Statement of Truth:

I believe the contents of this document to be true.

SIGNED [I/S]

MR ROBERT WADE

DATED 04/06/2025

WITNESS STATEMENT OF ROBERT WADE PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

APPENDIX A – LIST OF DOCUMENTS WHICH I HAVE

I. Inquest bundle:

i. Statements:

1. A family profile, 24/05/15
2. HCA 1 (HCA), 03/11/15
3. An analysis of Richard's intentions and their consequences, by Robert Wade, 23/05/15
4. Wrd Mngr 17/05/15
5. [I/S] (paramedic), 31/07/15
6. [I/S] (clinical manager), 08/07/15
7. Loc Dr (psychiatrist), 31/07/15
8. Stf Nrs 1 (nurse), 02/06/15
9. [I/S] (police inspector), 10/06/15
10. DI undated
11. HCA 2 (HCA), 02/06/15
12. [I/S] (PC), 28/05/15
13. [I/S] undated
14. Linda Wade (family), 24/05/15
15. S/Worker (support worker), 17/05/15
16. S/Worker (support worker), 24/05/15
17. NEP, undated
18. [I/S] (CPN), 03/06/15
19. MHA (mental health practitioner), 10/06/15
20. [I/S] (PC), 29/05/15
21. DI (DI), 01/06/15
22. [I/S] (PC), 28/05/15
23. [I/S] (support worker), 02/10/15
24. Robert Wade (family), 22/05/15
25. Robert Wade (family), 25/05/15
26. [I/S] (family), 24/05/15
27. Nrs 1 (nurse), 14/06/16
28. Nrs 1 (nurse), 21/07/15
29. Stf Nrs 3 (Charge nurse), 17/05/15
30. Stf Nrs 3 (charge nurse), 11/08/15

ii. Medical Records

1. Broomfield Hospital
2. East of England Ambulance Service Log
3. GP Records, Beachamp House
4. NEP records

iii. Reports, Policy, Procedures, Training and Other Documents

1. Bleep Handover Sheet, 16/05/15
2. CPA Assessment/Remedy, 16/05/15
3. CQC Quality Report, The Linden Centre/Finchingfield Ward, 20/05/15
4. Essex Police Incidents, undated
5. Essex Police Property Entries
6. Interview summary with HCA 1 undated
7. Joint Psychiatric & Physical Assessment Form, 17/05/15
8. List of Contraband Items – Arrival at the Linden Centre, April 2014
9. C/Psych (Consulting Psychiatrist), 16/11/15
10. NEP Admission Procedure Policy – Implementation date 24/11/14
11. NEP Care Programme Approach & Non-CPA Policy and procedure, Implementation date August 2014
12. NEP Clinical Risk Management Protocol (Incorporating Clinical Risk Assessment Tools Handbook) – 2013 Edition
13. NEP Incident reporting policy & Procedures – Implementation date 03/12/14
14. NEP Inpatient observation and engagement policy- Implementation, March 2014
15. NEP Management of ligature risks in mental health inpatient units- Implementation date August 2015
16. NEP Temporary Staffing Solutions, undated
17. NEP Searching of service users and their property policy, 21/11/14
18. NEP Serious Incident Investigation Report, December 2015
19. Police ISR Reports
20. Post Mortem Report by Pthlgst (pathologist), 19/10/15
21. Prevention of Future Deaths Report
22. Record of Inquest
23. Review of NEP SIIR, by Robert Wade, December 2015
24. Richard's belonging's list, 26/05/15
25. Training records for relevant staff
26. Transcript of calls with Suffolk Police
27. Serious Incident Investigation Report
28. Staff notices on restricted items
29. Work roster – 300 Finchingfield Ward, May 2015
30. 72 Hour report into Richard's Death

II. Inquiry bundle:

i. Statements:

1. Commemorative Statement by Robert Wade

III. Documents held by our client:

i. Interview transcripts

1. HCA 1 (HCA) x 3
2. [redacted] (healthcare assistant)
3. Wrd Mngr (ward manager) x 2
4. Stf Nrs 1
5. Chg Nrs (nurse)
6. HCA 2 (HE) x 2
7. S/Worker (support worker) x 2
8. [I/S]
9. Stf Nrs 2 (nurse) x 2
10. MHA (mental health nurse)
11. [I/S] (Agency healthcare assistant)
12. Nrs 1
13. Stf Nrs 3

ii. Other documents

1. Action Plan, EPUT 0904.14, undated
2. Analysis of death of Richard Wade, by Robert Wade
3. E-mails between CQC and Robert Wade
4. E-mails between I/Dir Q (NEPT) and Robert Wade
5. E-mails between DI (Essex Police) and Robert Wade
6. E-mails between NEPT and Robert Wade
7. NEP meeting notes – meetings with Robert and Linda Wade