WITNESS STATEMENT OF DAWN JOHNSON
PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, Dawn Johnson [redacted] **[I/S]**), am the daughter of Iris Scott (5th December 1940. DOD: 1 March 2014), who I will refer to as 'mum' throughout my statement.

2. I am making this statement based on my recollection and the documents that I already had in my possession before the beginning of this Inquiry. These include my mother's medical records, inquest bundle documents from 2015 which include my own witness statement dated 11 April 2015, a Serious Incident Review dated 8 June 2014, photographs, my mother's own items and handwritten notes and diaries from her final admission, my handwritten notes from my mother's final admission, and recordings.

3. Where I make reference to the records of the GP, NEPT or the Ambulance Service, this is based on my understanding from the review of the records that my legal team have undertaken in response to the Inquiry's Rule 9.

Diagnosis

<u>When mum first became unwell</u>

4. Mum's first ever episode of depression was in November 2007 **[Page 7, GP records].** I understand that her GP recorded, *'[s]leep problems since moved to Chelmsford was in her previous house for 40 yrs misses it thinks about it and gets panicky (sic)'* **[p.7, GP records].**

5. I understand that mum's GP records show that a range of medications were tried in November 2007 including Amitriptyline, Zopiclone, Citalopram, Diazepam, Fluoxetine, and Temazepam **[pp.7 - 8, GP records]**

6. On 19 November 2007, mum's GP made a counselling referral, and on 30 November 2007 her GP made a referral to a private psychiatrist **[p.8, GP records].** On 4

December 2007, we took mum to The Priory for a private psychiatric assessment. An entry from this date shows that Dr [I/S], wrote to mum's GP stating: *'… I understand you started her on Citalopram, which she didn't tolerate. She is now on Fluoxetine 20mg a day, which she is tolerating. She is also on Lorazepam 2mg to 3mg per day and Temazepam 20mg at night. Despite this she is not sleeping well and is still agitated in the day'* **[pp. 76 - 77, GP records]**

7. I understand that Dr [I/S] confirmed in his letter that he had agreed a treatment plan with mum: ' *…We will need to give the Fluoxetine a number of weeks yet to see if it's going to help her. It will be important to start reducing the Lorazepam in three to four weeks, to stop it within six weeks, so that she doesn't become dependent on it. Likewise with Temazepam. If she is still needing tranquilizers and hypnotics at that time, you might try her on some Risperidone in the day and Mirtazapine or Amitriptyline at night … There is a 70% chance that she will recover well.'.* **[pp. 76 - 77, GP records]**

8. I understand that Mum's GP records show that on 6 December 2007, she was prescribed Lorazepam, with her Citalopram and Temazepam prescriptions cancelled **[p.9 , GP records]**. They show that on 10 December 2007, she was prescribed Fluoxetine and Zolpidem and on 20 December 2007 the plan was to take Lorazepam at night instead of Zopiclone **[p.9, GP records]** By 20 December 2007, a CMHT referral was noted as *'being processed'*, following a referral by her GP on 13 December 2007 **[p. 79, GP records]**

9. In early 2008, mum started to show signs of anxiety by pacing up and down. We called the Mental Health Crisis Team when she was assessed by a psychiatrist called Dr [I/S]. Dr [I/S] prescribed mum a sedative and shortly afterwards mum seemed to calm down and go back to her normal self.

10. I understand that mum's GP records show that on 3 January 2008 she was seen as an outpatient at the Linden Centre, and assessed at home on 8 January 2008 **[p. 78, GP records]**. Following this assessment, the CMHT wrote to mum's GP: *'Iris has a diagnosis of moderate to severe agitated depression'* and that a treatment plan had been agreed to include Diazepam, night sedation added with Zopiclone and Promethazine, to stop Fluoxetine, and to start Duloxetine **[pp. 82 - 83, GP records]**. The plan also included *'[o]nce daily home treatment to monitor her mental state, offer her support and reassurance'* **[pp. 82 - 83, GP records]**

11. On 21 January 2008, I understand that Dr [I/S], a psychiatrist, noted that mum had *'started Fluoxetine in early December and this has probably [began] to start working as well as the effect on her sleep from the Lorazepam improving her mood. She has had Zopiclone in the past which was a variable help. She has had Amitriptyline which gave her major side effects and Citalopram gave her abdominal cramps. She has been given Diazepam in the past but never taken them. Currently she is taking up to 4mg of Lorazepam a day which I am sure [is] an extremely bad idea so I have substituted this for regular 2mg of Diazepam I have suggested to her that she only use Lorazepam to help her sleep if she has been sleeping badly for a few nights … We will leave the dose of Fluoxetine at 20mg at the moment and I will reassess her in 6 weeks'* **[p. 84, GP records]**

12. On 31 January 2008, I understand that the records show that mum was discharged to the care of the CMHT with [I/S] as her care-coordinator **[p. 86, GP records]**. She continued to receive medication, which included Promethazine **[pp. 10 and 86, GP records]**

13. On 3 March 2008, I understand that Dr [I/S] wrote to mum's GP outlining the changes to her medication plan: '*Reduce Diazepam, Zopiclone and Promethazine to PRN … I have suggested to her now that she makes the Diazapam, Zopiclone and Promethazine PRN only but continues with the Duloxetine. As this is her first episode of depression I think we should continue the Duloxetine for 6 months only before stopping it. However experience has shown that stopping it too early undoubtedly precipitates new depressive episodes so this length of time should consolidate her recovery. Our plan for the future would be to review her again in 3 months time and if all is well I will then discharge her back to your care.'* **[p. 87, GP records]**

14. On 1 July 2008, I understand that Dr [I/S] wrote to mum's GP stating that mum was *'very much better and certainly no longer seem[ed] depressed'*, noting that she was *'sleeping very well without any of the hypnotics and sedatives'* **[p. 90, GP records]**

15. Dr [I/S] advised that mum should continue her medication until the end of September and if there were no further issues then the plan would be *'to reduce Duloxetine to 30mg per day for a few weeks and then on alternate days for a few weeks before stopping'*. **[p. 90, GP records]**

16. Mum was discharged on 1 October 2008 with a plan in place to have weaned off her antidepressants within three months **[p. 91, GP records]**

17. In November 2011, when mum started to experience poor sleep **[p. 21, GP records]**. She was prescribed Zopiclone and Diazepam on 2 November 2011, with the drugs being cancelled on 2 December 2011 and 16 December 2011 respectively **[p. 21, GP records].**

Mum's episode and assessment in 2013

18. Mum's anxiety returned in early 2013. Around this point, mum was experiencing dental problems and poor sleep. She was also affected by some personal problems my brother **[I/S]** was facing at that time back in Germany, and my dad's health problems which had been on-going since around December 2012. By 2013, we were all much older and busy with our own lives. I think that mum might have felt a loss of purpose at this point, because she was always the 'do-er' in the family.

19. Mum's GP prescribed Zopiclone on 18 March 2013 and Diazepam on 25 March 2013 **[Page 24, GP records]** On 17 April 2013, her GP noted that the Diazepam had *'not been effective'* and prescribed a higher dose of it along with Sertraline **[p. 24, GP records]**. On 22 April 2013, GP planned to refer her to CMHT **[p. 24, GP records].** This was done on 25 April 2013 **[p. 174, GP records].**

20. I understand that the records show more medication changes followed and by 6 June 2013, mum's GP noted that she was *'worse again after reducing the drugs … will have to refer to psychogeri (sic)* **[p. 25, GP records]**. On 7 June 2013, NEPT confirmed that they had received the GP referral **[p. 110, GP records].**

21. Mum's first appointment with NEPT took place on 26 June 2013 with Dr **[I/S]** at the Crystal Centre, which dad and I accompanied her to. Following this, Dr **[I/S]** visited mum at home. I recall that when mum would request a change to her medication plan, Dr **[I/S]** would do this. He seemed to be more concerned with doing what mum wanted rather than, from my non-medically trained perspective, what might have been the best clinical option for her. I felt that this was strange but as I was not a doctor, I did not raise my concerns at this stage.

22. The table below shows some of the changes to mum's medication from 26 June 2013 until mum's final admission on 30 August 2013.

DATE	CONTENT *(sic)*	EXHIBIT
26.6.13	*'Following her new patient appointment with me today, I would be grateful if you could kindly consider the following change to her medication: (1) T reduce [down] Duloxetine to 30mg more for 1 week, then stop it … MIRTAZAPINE 15mg nocte. (2) To gradually reduce Diazepam. Continue current dosage of 2mg mane, 2mh midday, 4mg nocte for 1 week, then reduce it to 2mg TDS x 1 week and thereafter 2mg … (3) to stop the promethazine and reduce the dose of zopiclone to 3.75mg after 1 week & thereafter*	**p.111 GP records**
27.6.13	*Diazepam 2mg – 28 tablets, Mirtazapine 15mg – 28 tablets, Zopiclone 3.75mg – 28 tablets*	**p. 27 GP records**
5.7.13	*Diazepam 2mg – 28 tablets*	**p. 27 GP Records**
5.7.13	*Started Mirtazapine*	**Mum's 2013 diary**
17.7.13	*Following the outpatient clinic appointment with me today, could you kindly consider prescribing* *1. Temazpam 10mg nocte … & stopping the Zopiclone.* *[illegible??]* *2. I have also asked her to use Diazepam 2mg at 0900 + 1400 hrs & PRN 2mg if needed … to supplement the* *BD dose* *3. … could you [??] mirtazapine to 30mg after 1 week*	**p. 115 GP records**
18.7.13	*Diazepam 2mg – 28 tablets, Mirtazapine 30mg – 28 tablets, Temazepam 10mg – 28 tablets*	**p. 27 GP records**

22.7.13	*'Plan – medication changes* *1. To introduce Tamezepam 10mg nocte and increase to 20mg according to clinical response* *2. To prescribe Diazepam 2mg at 09:00hrs and 14:00hrs as well as 2mg PRN ad to top up regular dose if necessary*	**p. 27** **GP records**

	*3. **To stop Zopiclone*** *4. To increase Mirtazapine to 30mg nocte after one week, o.e. from the 25th July 2013* ***… P.S. I have received your letter dated 22nd July advising of restarting Zopiclone** and Duloxetine and continuing with diazepam. **I am fine with this'***	
24.7.13	*Plan: stop mirtazepine (sic)/restart duloxetine 60 nocte/stop temazepam/restart zopiclone 7.5 nocte.* *Continue diazepam 2mg.*	**p. 28** **GP records**
24.7.13	*[GP Dr* **[I/S]** *letter to Dr* **[I/S]** *'I have re-instituted some of the medication in the hope that **it might help put her back on an even keel for the time being**. 1. She feels that Mirtazapine has upset her and as you yourself said that she could stop it, I have told her to do so. 2. I have asked her to restart Duloxetine **60mgs daily** 3. She does not feel that the Temazepam helps at all so I have asked her to stop that and restart Zoplicone 7.5mg 4. I asked her to continue on her Diazepam 2mg twice daily*	**p. 166** **GP records**
1.8.13	*To stay on Zopiclone and Diazepam and Duloxetine. …* *Quetiapine 25mg – 58 tablets*	**p. 28** **GP records**

2.8.13	*[Dr* **[I/S]** *– locum consultant psychi, care plan to Dr* **[I/S]** *'Despite taking the prescribed medication she does not seem to have experienced a beneficial effect. I understand that her anti-depressant was changed recently by Dr* **[I/S]** *to Mirtazapine but she only took it for one week because she felt anxious and you kindly changed it back to Doluxetine 60mg mane.' …I understand you recently recommenced Zopiclone and stopped the Temazepam … Impression: Agitated Depression with heightened levels of anxiety Plan: To commence Quetiapine 25mg nocte for two days and increase to 25mg bd on day three …*	**pp. 124 – 125 GP records**
5.8.13	*I suggest that you stop the Quetiapine and start on Olanzapine 2.5mg nocte to begin with*	**p. 126 GP records**
9.8.13	*Has stopped taking the Quetiapine as did not agree with her. Now taking Olanzapine – not happy taking. Lots of questions regarding medications. Still very anxious. Consultant is doing a home visit next Wednesday to review. Also has regular visits from CPN. Plan: To continue with current meds and review with consultant next week.*	**p. 28 GP records**
15.8.13	*Seen by Dr* **[I/S]** *… Has had prescription changed today, fax received to stop Olanzapine and start Quetiapine 25mg notce (sic) and to increase dose of Diazepam.ing (sic) back to Queitapine and increase dose of Diazepam … Reviewed as planned by CMH team and consultant psychiatrist. Review by GP if at all concerned … Quetiapine 25mg – 60 tablets Diazepam 2mg – 112 tablets Duloxetine 60mg – 28 capsules Zopiclone 7.5mg – 28 tablets*	**p. 29 GP records**
16.8.13	*[Iris] has observed that since start Olanzapine there seems to have been a worsening in her restlessness and I thought perhaps she could be experiencing akathisia … In view of this I request that Olanzapine is stopped and replaced with Quetiapine'*	**p. 131 GP records**

23. I understand that according to NEPT's records, it was on 27 August 2013 when Dr [I/S] considered that mum needed to be admitted to hospital **[p. 30, NEPT Bundle 1]**. I recall that at this point there were no beds available until 30 August 2013.

Admission

24. Mum was admitted to Ruby Ward ("the ward") on 30 August 2013 as a voluntary patient. I was not there on this day because I was at a family wedding. My brother, Craig Scott, and my dad attended this admission with mum. I understand that the plan from this day was that mum would stay at the ward for approximately three weeks.

Ward environment

25. I visited the ward a lot. At one stage, after Christmas, I think I was signed off work as I was having to care for dad and visit mum. To understand how inappropriate the ward was for mum, it is important to understand mum's characteristics. She was not a typical 73-year-old. She was very intelligent, played cards, and she did sudoku and crosswords. Mum was very active and had a very big social circle. She loved to be outdoors.

26. I would say from my perspective that most of the patients on the ward had dementia. This frustrated mum because she was not able to engage with them. In the main area of the ward, patients played cards and there were puzzles available. The activities available to mum were low level and she was frustrated by this and needed more social interaction and stimulation.

27. Similar concerns were even highlighted by NEPT staff themselves on different occasions, which I set out below:

    a. [I/S] a registered mental health nurse at NEPT, provided a witness statement for the inquest into mum's death, stating, '*The Crystal Centre has two inpatient assessment wards. Topaz … and Ruby which is a mixed 17 bedded ward for clients with functional illness. Unfortunately due to lack of available beds on the Topaz ward during 2013, several clients with a diagnosis of dementia had been admitted to Ruby ward for assessment. The mix of*

clients different presentation[s] and needs created an unsettled ward environment….. Due to severe staff shortages I transferred from the Topaz to the Ruby ward in June 2013'. She went further to say that *'… [u]nfortunately the majority of clients on the Ruby ward at this time had a diagnosis of dementia and frequently their behaviour caused distress to the few functional clients. This appeared to cause the most upset to Mrs Scott.'* **[§§ 3 - 6, [I/S] [I/S] witness statement, 2015].**

b. On 17 September 2013, NEPT staff recorded that *'Iris has said that she feels flat in mood and feels that she has no connection with the other clients therefore spends so much time on her own'.* **[Page 40, NEPT Bundle 1].**

   On 23 October 2013, NEPT staff recorded that *'Iris was upset when one of the clients went into her room and opened his bowels on the chair and bed … she reports he punched her.'* **[p. 59, NEPT Bundle 1; p. 42, NEPT Bundle 2]**. Even though I rang the ward on 24 October following mum's suicide threat (see below), I did not know about this incident until my legal team's review of NEPT's records in response to Inquiry's Rule 9 request.

28. On 10 September 2013, mum made a handwritten entry in her diary stating, *'Calling out in night. Still have very little sleep.'.* The next evening, she made another entry stating, *'Still calling out in night. Woken by alarm – 2.30. Although requested not to lights switched on'* **[Mum's 2013 diary]**. I think this refers to an incident where mum wanted the lights to be turned out, but the staff kept on switching the lights on. I do not know what the *'calling out'* comment refers to.

29. Mum had her own reading materials, she would listen to music or go out into the garden. There were group activities focusing on mindfulness and Tai Chi but mum was not always cooperative there. I think she might have been banned from attending some of the group events at some point. I understand that an entry by a NEPT staff member from 18 February 2014 states that mum had participated in a group exercise but *'found it too easy'* **[p. 126, NEPT Bundle 3]**

30. Overall, I think going from being a very active person to having none of the normal stimulation she would usually have made her worse.

31. This situation became even worse for mum after her first ligature attempt on 14 January 2014, which mum told me about during a phone call on 15 January 2014 (see below). From this point she was not allowed in her own space alone. Her bedroom door was locked and she had to stay in the main area of the ward all day from around 9am to 10pm. A handwritten note from 18 January 2014 states, *'Cannot have tapes or i-pad … Must stay in one area.'* **[Iris Scott's notes]**. I understand that records show she was supervised when blow-drying her hair **[p. 52, NEPT Bundle 3]**. I also understand that the records show that on 19 January 2014: *'Staff supervised her with change of clothes'* **[p. 52, NEPT Bundle 2]**. An entry dated 23 January 2014 states, *'[u]pset about consequences – being observed when in the bathroom, having to blow dry her hair outside'*.

32. I think mum lost hope at this point because she could not see how she was going to get out of this situation. These are reflected in her own handwritten notes. On 28 January 2014, mum made a diary entry stating, *'[t]hinking about situation now in. Humiliation of undressing'* **[Iris Scott's notes]**. The next day, she made another diary entry: *'Lights keep switching on. Awake 1.15am onwards. Thinking about family. How long before things improve'* **[Iris Scott's notes]**

33. On 23 January 2014 at a CPA meeting in person at the ward. I expressed my concern to the staff that mum was spending too much time on her own in the dining area and asked if there was anyone available who could sit with her more. One of the staff members at this meeting told me that they had a senior Occupational Therapist called [I/S] who she would ask to see if she could spend some time with mum. On 30 January 2014, I made a journal entry stating, *'Informed* [I/S] *mum not engaging or enjoying CBT sheets / occupational therapy or tai chi … Are there no volunteers that can talk to mum – left alone 12hrs a day!!'* **[pp. 63 – 64, DJ diary]**

34. The ward environment was clean but beyond that it was not fit for purpose. We considered taking mum out of the ward and getting her into private care instead, but this would have cost us around £5000 a week which we did not have, and we did not want mum to be discharged home without the crisis team.

Staffing arrangements, training and support

35. There was a significant lack of staff on mum's ward. This was especially so during change over times, when there could be just one staff member walking around the ward. I remember occasions when there were patients on the floor or sliding out of their chairs and there were no staff around.

36. In terms of other staff and healthcare workers on the ward, I remember that there were a lot of banks staff, and that there some staff members were carrying out many different roles. For example, before Christmas there was a woman regularly serving the dinners and then the next time I saw her she was out on the ward. I question what training, skills and experience she had to do so.

37. For mum, the lack of staff meant that she had no continuity in her medical care. Although I do not endorse the SIR following mum's death (for reasons which I set out below), I will make reference to some of its findings throughout this statement for completeness. The SIR identified that she had three doctors and various nurses in her six-month admission, which combined created *'a difficulty in providing a clear and consistent overview to meet [Iris'] needs.'*, and also notes that there *'were a number of vacancies within the nursing team'*. **[pp. 10 – 11, SIR].**

38. We were very concerned about these changes and we raised questions about them all the time. I think that Dr [I/S] oversaw mum's care until November 2013. I remember that when Dr [I/S] was coming off mum's case, the ward manager said to me that things would improve because Dr [I/S] was *"a bit of a ditherer."* I understood that comment to mean that she was happy that someone else was going to take over and hopefully steer mum's care in the right direction. I do not recall being given any reasons as to why he was coming off her case or what mum's diagnosis even was at this point. I do not think I met Dr [I/S] because she went on maternity leave. I believe Dr [I/S] only saw mum once and then was off sick before going on maternity leave, and that mum had no assigned psychiatric care until around 9th January 2014 when Dr [I/S] then took over mum's psychiatric care.

39. In addition, there were certain staff members who just should not have been working on a mental health ward. The ward manager [I/S] was never warm and she never came across as even mildly concerned.

40. The SIR panel also *'found little evidence that … the Keyworker was playing an active role in her care. Almost all care plans appear to have been written by other staff.' …*

'The Keyworker did was not routinely allocated to [Iris] (especially in later stages of admission).' … The Keyworker did not undertake any risk assessments'…'There is no evidence that the Keyworker evaluated any care plans' **[p.13, SIR].**

41. In her statement for the inquest into mum's death, [I/S] said: '*I found that complexities of Mrs Scott's presentation difficult to manage and I believe that as an experienced nurse I should be able to manage her presentation and care. I therefore questioned whether I was doing something wrong. I requested advice from the psychologist at the time who stated that he also found Mrs Scott difficult to manage but could not advise me further … I also asked Dr* [I/S] *whose only suggestion was to hand over the key working role to another member of staff. As there was only one other full time and one part time qualified staff on the ward at the time, and they were relatively inexperienced I advised Dr* [I/S] *this was not possible.'*. **[§§1517,** [I/S] **witness statement, 2015]. Leave**

42. During mum's final admission, she did go on some home visits. I believe [I/S] accompanied her on these visits, and that some of them did not go well. On one occasion for example, mum tried to get out of the car as it was moving on the road.

43. When I would visit mum, I remember we would sometimes leave the ward together. Mum liked to be in the garden so we would go for walks. There was not much interaction between us and the staff. I do not remember being given any specific time to be back or being given any specific contact details to call in an emergency, although I would have called the ward if there were any issues.

44. There was a book to sign in and out of at the ward, but I do not remember ever formally signing in or out with an actual staff member. This was just on the side by the nurses' station for us to do. Whenever I returned to the ward with mum, I was not asked any questions by the staff about how mum had been on the visit or how the visit had gone.

45. I do not think that the staff knew where mum was when we would go out together. As an example, on 19 December 2013, mum left the ward on her own and went into the parking where an incident took place that resulted in her being sectioned.

46. Another example is that on 23 January 2014, I made a handwritten entry in my personal diary stating, *'4:50 spoke to ward* [I/S] *asked to speak to mum & she asked me to ring outside number. Mum was let out of ward by herself!! So why securing in*

ward when she can run away.' **[p. 52, DJ diary]**. It would be interesting to know if NEPT kept a record of when mum left the ward and when she returned.

Overall observations on treatment and care management

47. Mum's diagnosis, treatment, care plans, self-harm incidents and our complaints as a family were all linked together. Rather than addressing them separately in line with the structure of the Rule 9 request, I will address them chronologically to assist the Inquiry to follow the sequence of events. I take this opportunity to provide my overall observations on mum's care and treatment.

Diagnosis and treatment

48. The initial impression was that mum had *'Moderate Depressive Episode (Recurrent Depression) with associated sleep disturbance and prominent somatic anxiety symptoms'* **[pp. 2 – 5, NEPT Bundle 1]**. However, looking back, mum never had a confirmed diagnosis in her final admission. The SIR said: *'[t]here were … divided opinions amongst the staff caring for [Iris] including the doctors and consultants who treated her regarding the relative importance of a diagnosis of agitated depression, and/or issues relating to her personality (for example personality disorder)'.* **[p. 14, SIR].**

49. At 16:40 on 26 February, I understand that the records show that mum was referred by her psychologist [I/S] to Central Older Adult Psychology for an assessment **[p. 23, NEPT Bundle 1];** and that psychology report from 28 February, *'confirmed [mum] was not suffering from depression but indicated an increased level of anxiety beyond what might be expected in everyday life.'* **[p. 126, NEPT Bundle 1]**.

50. To me it seemed as though the team were not treating mum for how she was presenting. They did not take what they were seeing and reacting to that. They were focused on treating the underlying cause for mum's presentation, which they considered was triggered by the private and personal issue in mum's past. As a family we wanted mum to receive PRN medication so that her anxiety could be controlled and then allow for more effective diagnosis and treatment of her underlying condition.

I understand from Craig that on one of his visits to see mum at the Linden Centre, she was very agitated and after being given PRN she calmed down.

51. I do not think that there was a week or even a few days that passed that we as a family did not have to approach the desk at the ward and ask about mum's medication and what the next steps were in her treatment. We would ask to speak to someone about her care and it was only after mum's ligature attempt in January 2014, which I go into below, that [I/S] spoke to us.

52. Another example of the lack of engagement that we had as a family relates to mum's brain scan. We understood that she had been referred for a brain scan to assess whether she had any problems with her frontal lobe. We kept asking for the results of her scan but it was not until the end of January 2014 that NEPT informed us of her results even though the records show a scan was requested on 3 December 2013 **[pp. 204 – 205, NEPT Bundle 2]**, and according to the SIR the scan went ahead on 17 December 2013 **[p. 26, SIR]**. I recorded my concerns in my own diary; noting on 1 January 2014, that I had repeatedly asked for mum's scan results and on 10 January, that I was still trying to find out her scan results having left two messages **[pp. 16 - 19, DJ diary]**. As I will detail below, the ward did not even contact us when mum sustained significant injuries to her face and teeth in January 2014. Overall, I would describe NEPT's communication with us as a family as a one-way street.

53. As for NEPT's engagement with mum when care and treatment planning, I know that mum complained very frequently her medication not helping her. I am not sure that the staff took her views into account. In mum's handwritten notes from when she was at the ward, she referred to being refused PRN when she asked for it; and I understand that this is confirmed by NEPT's own records **[p. 72, NEPT Bundle 1; p. 39 NEPT Bundle 2]**. My impression was that the care and treatment plans were set and then Craig and I would be informed, with mum being the last to find out about any plans. Mum made an undated journal entry stating, '*[a]s I said what do they mean by care plan'* **[Iris Scott's note]**. The SIR panel found that there was *'only limited involvement of [Iris] in her care plan'* **[p. 18, SIR].**

54. The view of the SIR panel reviewing mum's care and treatment was that '*a more systematic approach to treatment resistant depression at an earlier stage might have led to a more 'aggressive' treatment with medications for a resistant agitated*

depression, and may have enabled a more productive psychological approach' **[p. 21, SIR]**. They considered that *'it may have been an advantage for her to have similar support at home'* which she had received when she was *'treated at home with crisis team support and medication'* around 2007 and 2008 **[p. 13, SIR]**. The SIR panel also made some findings about the record-keeping of staff in relation to mum's care plans:

a. *'In general the documentation was copious but disorganised'* **[p. 10, SIR]**

b. *'The task for the care team was made harder by the introduction of a new electronic records system (Remedy) which caused a number of issues, for example many staff (especially bank staff) were unable to access Remedy for period of time and in some cases for many months. As a result, the team had to coordinate historical electronic records (Carebase), new electronic records (Remedy) and paper records'.* **[p. 10, SIR]**

c. '[In November 2013], *[m]any staff had difficulty accessing or were completely unable to access Remedy. This applies to most bank staff, many of who [sic] did not have any access at all.' 'it was clear that these events hampered the access to information about … [Iris] and that this is likely to have affected her care.'* **[p. 11, SIR]**

d. *'Historical information about [Iris] (pre-November 2013) was held on Carebase. From November, new information such as daily progress notes were split between Remedy and paper records with further information being on email and the shared drive' 'The panel believe this complex system could have contributed to the difficulty in coordinating information about Mrs S. This in turn could have had an impact on the formulation of the treatment plans.'* **[p. 12, SIR]**

Safety and concerns

55. Throughout mum's admission, we were very concerned for mum's safety because of the attempts that she had been able to make on her own life while at the ward. We were concerned that on occasions they did not believe that mum had done so and they failed to investigate and act on our disclosures about her self-harm. I understood

from the staff at the ward that they had a policy book, about safety and risk, on their shelves for reference but I recall they said that they did not have the time to read it.

56. The SIR found that throughout mum's *'admission there has been little evidence of systematic assessment and planning of risk or care'* **[pp. 10 – 19, SIR].** It added that *'[i]n [Iris'] case there was a lack of structure to the assessment and care planning process. Care Plans were implemented which address changes in the perceived risk for [Iris] and measures to maintain safety were implemented but they appear in isolation with no direct link to the assessment',* and, *'not all Ruby Ward staff were able to demonstrate an awareness of risk assessment and risk management process'* **[pp. 10 – 19, SIR].**

57. We also had concerns that mum was being mistreated by some of the staff. Mum had said that sometimes a particular staff member would give her a little nudge when she was walking. I expand on further instances of this below. An undated entry in my mum's diary states: '*Dawn / pls be careful what you say I only said it once – now they are ignoring or sending me to my room if I am agitated and they will stop my visits – I am not being hysterical but please believe me – now you have told them my anxiety level has risen and they are just ignoring me.'* **[Iris Scott's note]**. In her statement for mum's inquest **[I/S]** commented that on 20 February 2014 nursing staff said that mum had complained about staff being liars and bullies **[§14, [I/S] witness statement, 2015]**.

September 2013

58. I understand that NEPT's records show that mum was on Level 1 observations in September. The SIR has commented that the *'rationale for change not documented'*. **[p. 24, SIR].**

59. On 7 September, Craig and dad visited mum. I understand that NEPT's records state that they both felt that mum was *'worse [there than] at home]'* **[p. 34, NEPT Bundle 1]**. After a discussion with the duty doctor that day, mum was prescribed PRN Promethazine *'to help her sleep'* which she took with Diazepam **[p. 75, NEPT Bundle 1]**. The SIR notes that mum was taking Diazepam, Quetiapine, Zopiclone and Promethazine as at 8 September **[p. 24, SIR].**

60. I understand that the records say that on 17 September, mum was seen by a psychologist, and it was noted that this *'improved her mood'* **[p. 39, NEPT Bundle 1]**. I understand that records from the following day state that mum had expressed that she was *'concerned as she felt psychology was only asked to work with her because of feeling guilt around her thoughts [surrounding the private and personal issue], which she felt] was not the cause but was one of her worries'* **[p. 40, NEPT Bundle 1]**. I understand that on 13 November 2013, mum told Dr [I/S] that she had not come to hospital because of any feelings of guilt relating to that issue, but that she had come to hospital because of her low mood and that *'she found things were getting on top of her'* **[p. 101, NEPT Bundle 2].**

61. By 30 September, mum's treatment plan was to *'[t]rial pregabalin' and to 'encouraging participation in ADH + psychology'* **[p. 89, NEPT Bundle 2]**. **'**ADH' stood for the Amethyst Day Hospital which I know mum did attend on occasions.

October 2013

62. I believe that mum remained on Level 1 observations in October.

63. I understand that on 7 October, the plan for mum's treatment was that she would continue to take Pregabalin but that the final aim was to reduce Diazepam, increase Pregabalin and to continue psychotherapy **[p. 91, NEPT Bundle 2]**. By 21 October, mum's treatment plan was to increase Pregabalin and *'continued (sic) psychology'* **[p. 94, NEPT Bundle 2]**. The SIR notes that *'the antidepressant Duloxetine was reduced in dose. The intention of this, Dr* [I/S] *told us was to combine the antidepressants Duloxetine and Mirtazapine' … 'This is not an accepted combination for the treatment of resistant depression'* (it goes on to explain why in the panel's view it could be acceptable) **[p. 15, SIR]**. It is therefore unclear to me exactly what medication mum was on in October.

64. On 24 October, I was due to go to Cornwall. I spoke to mum on the phone when she wished me a happy anniversary. While we were on the phone, she told me that she

would not be there when I got back from Cornwall. She told me that she could no longer live the way that she was and she did not want to be where she was.

65. After this conversation and on the same day, I called the ward and spoke to [I/S], the ward manager. I told her what had happened and she responded with words to the effect of, *"nothing was going to happen"* and that I was just being a *"paranoid daughter"*. [I/S] said that mum was trying to increase my anxiety. She went further to say that if I did not calm down, that the ward would be treating me as well.

66. I do not think that my disclosure to [I/S] was recorded on NEPT's systems on that day or that this led to any change in mum's observation levels or risk assessment as I understand this does not appear in her records at the relevant date **[p. 60, NEPT Bundle 1]**. I understand that there are entries on NEPT's systems dated 4 November 2013 which state that **'***[Iris'] daughter has said her mother voiced a concern that she would 'end it all' in a phone conversation – no specific plan was said'* **[p. 95, NEPT Bundle 2]**. If this entry and appointment relates to my disclosure on 24 October, then it implies that mum was only spoken to about my disclosure around 11 days later.

November 2013

67. I understand mum's medical records state that on 4 November when mum was seen in relation to my disclosure about her threat to self-harm, that mum '*denied suicidal ideation [and] said she [had] voice[d] some suicidal ideation to her daughter however she believes she is not brave enough to do it + wouldn't put her family through it. She said she is frustrated but wouldn't hurt herself'* **[p. 95, NEPT Bundle 2].**

68. I understand that the same entry notes that the plan for mum from this point was for her to write *'her thoughts down on paper as this would be a good way to think clearer + slower and reflect on how her thoughts change throughout the day [2] Continue gabapentin 50mg BD 3. [illegible]'* **[p. 95, NEPT Bundle 2].**

69. 8 November, my mother expressed to the staff that she wanted '*to kill herself'* and they noted her as having *'high anxiety depression'* **[p. 34, NEPT Bundle 2]**. On 9 November, mum *'disclosed that during ward round last week she had stated to the team that she wanted to kill herself'* **[p. 70, NEPT Bundle 1]** I understand that the

records show that Dr [I/S] discussed these disclosures with my mum on a ward round on 11 November, when mum said that she would not harm herself because she did not want to cause her family any distress **[p. 93, NEPT Bundle 1].** On the same day, we expressed our concerns a CPA meeting that we did not think mum had improved **[p. 98, NEPT Bundle 2]**. We were not informed by anyone about these threats and I have learned of them through this Rule 9 process.

70. For the rest of this month, I understand mum's care and treatment plans appeared to have gone through further changes. On 11 November for example, Dr [I/S] considered that mum was not suffering from severe depression **[p. 93, NEPT Bundle 1]**. He planned for her Pregabalin to be increased in dose.

71. Between 13 and 18 November, Mirtazapine was introduced into mum's medication plan **[p. 101, NEPT Bundle 2]**. I understand that on 18 November, mum told Dr [I/S] that her medications were not working and that she was not getting *'very far with'* her psychologist **[p. 83, NEPT Bundle 1]**. On the same day, I understand that the doctor that was due to take over mum's psychiatric care from Dr [I/S] considered that mum's diagnosis was still unclear **[p. 15, SIR]**. The SIR notes that in December 2013, there was still no clarity around mum's diagnosis in that the doctor viewed that '*while depressive illness played a part, personality issues were more important.'* **[p. 15, SIR].**
72. By 29 November, mum remained on Mirtazapine and her Duloxetine prescription was stopped, and on 30 November 2013, Dr [I/S] I was no longer involved in mum's care **[p. 29, NEPT Bundle 1].**

The decision to section mum in December 2013

73. I understand that on 3 December, Dr [I/S] who had taken over mum's psychiatric care from Dr [I/S] considered that mum was *'not responsive to medication'* **[pp. 204 – 205, NEPT Bundle 2].**

74. Dr [I/S] was due to go on leave around Christmas 2013. As I said in my commemorative statement to the Inquiry, Christmas was mum's favourite time of the year. We had tried to warn staff ahead of time that mum was likely to deteriorate around Christmas time at the ward. At this point, mum was not getting any effective psychiatric treatment and I was worried about this and the change over of staff during the Christmas holidays.

75. On 19 December, there was an incident in the car park of the ward which led to mum being sectioned. She had left the ward by herself and went into the car park. I was there and watched her approach my dad who was in the car park and behaved in a way that led the team to refer her for an assessment under the Mental Health Act.

76. I understand that the records indicate that Dr [I/S] requested the assessment **[p. 240, NEPT Bundle 2]**. I understand that the referral form which was produced at 15:00 on this day had left the '*Family Aware*' box unticked, and also noted that mum's diagnosis at this point was '*anxiety and depression*' and that mum was *'compliant with medication'* **[p. 19, NEPT Bundle 1].**

77. I made a note dated 19 December in my diary stating, *'Informed by* [I/S] *that due to mum's behaviour would have to … treatment under MHA section 2'* **[p. 1, DJ diary]**. Although this was a consultation with us, I feel that we were being told that this was what would happen.

78. I understand that NEPT's medical records suggest that mum was assessed under the MHA on 20 December when she was interviewed by two doctors including a Section 12 doctor called Dr [I/S] and an Approved Mental Health Practitioner ("AMHP") called [I/S] **[pp. 5 – 7, NEPT Bundle 1].**

79. I understand that the records state that **'***both doctors agree that Iris needs to be detained under S2 for her own health and safety and for the protection of others. Although she has agreed to medication she has constantly questioned this and her behaviour has become very unpredictable. Her scan results indicate a prodromal dementing illness. It is becoming increasingly difficult to nurse her as an informal patient due to her unpredictable behaviour. Both feel that she needs a period of further assessment and treatment'.* **[pp. 5 – 7, NEPT Bundle 1].**

80. I understand the same records state that the AMHP's views were: '*Iris appeared during assessment to have capacity and understood the reason for the assessment. However, despite agreeing to medication and not trying to leave her behaviour has become more aggressive and unpredictable. I agree with the doctors that she is becoming more difficult to manage as an informal patient and therefore detention for further assessment and treatment is necessary for the patients own health and safety and for the safety of others'.* **[pp. 5 – 7, NEPT Bundle 1].**

81. I cannot be sure about how the staff or doctors informed mum about this decision and what her own views about it were, but I refer to mum's handwritten notes which state, '*[t]hey seem to think I am putting it on to attract attention. I wish I could explain myself properly. I have never put anything on with regard to drawing attention to myself. I am worried about this Section (2) as to what is in it.'* **[Iris Scott's notes]**

82. On the same day, I made a handwritten note in my diary which shows how I came to be informed of the decision to section mum: *Informed by [?] mental health team that mum had been sectioned under 28 day rule.* **[I/S]** *phoned [and] explained that visits would also be restricted as were making mum agitated'.* **[pp. 1 – 6, DJ diary].**

83. My handwritten notes from this day go on to detail what happened when I visited mum following this phone call: '*informed at that time that visit would be restricted to 10 mins! ... On 10 mins was told had to leave. Mum very agitated.* **[I/S]** *accused me of holding up staff that were needed' ..* **[I/S]** *asked to speak to me outside in reception. She was very confrontational [and] accused me of interfering with mum's progress and because of my visit she would have to restrain [and] inject mum to calm her down [and] as a nurse she did not like to do this.' … She also stated that we should have (sic) to police for domestic abuse [and] not taken mum to hospital. [I explained my police background]. She then backed off but reiterated that [our] family was not complying [and] supporting nursing staff. [Conversation continued] I was nodding and she said don't just nod what you don't realise is your mum is not eating, drinking and sleeping and is dying basically. … I was very upset.'.* **[pp. 1 – 6, DJ diary].**

84. The following day on 21 December, I was informed that the ward was closed and that I could not visit or call mum until the following Monday **[p. 6, DJ diary].** I called the ward on the morning of 22 December and was told by the staff that mum was very agitated and that I could not speak to her on the phone **[pp. 7 – 11, DJ diary]**.

85. I spoke to mum at around 19:00 on 22 December. My handwritten notes from this conversation state, *'I spoke to mum very frightened [and] upset – not agitated. I asked her if* **[I/S]** *had given her anything or restricted her on Saturday or yesterday and she said she had … 1 extra diazepam and something else'* **[pp. 7 – 11, DJ diary]**. I also noted that mum said on that call that she was eating, drinking and sleeping. My

handwritten entry from this date states, *'I am very concerned with certain elements of mums treatment (sic)'* **[pp. 7 – 11, DJ diary].**

86. Not long after, I was informed by the staff that we would not be able to visit mum around Christmas time. I objected to this suggestion because, with Christmas being mum's favourite time of the year, it was the worst time to restrict our contact. I remember feeling that because the staff knew how much Christmas meant to mum, they used this against us to punish us for the way we questioned their treatment and care of mum.

87. It was around this time that I researched the details of an independent advocate to voice my concerns about mum's treatment and care to. The ward did not give me any such details or help me with where I could go to find an independent advocate. Through my own research, I encountered an independent advocate called **[I/S]** who came on board. **He** went on to voice my concerns to the ward, after which they uturned on their decision not to allowed us to visit mum during Christmas. On 24 December, they told us that we could go to visit mum.

88. On 24 December, I spoke to mum on the phone and recorded in my handwritten diary that she *'said she wanted to be dead. Felt alone [and that her] medication was wrong'* **[p. 11, DJ diary].** I also made a note that I felt that my telephone conversation with mum *'was being listened to'*. On Christmas Day, mum disclosed to me that *'she wanted to kill herself as she could not stand being a prisoner'* **[p. 14, DJ diary].**
89. I understand that NEPT's records indicate that on 24 December, mum's care plan was amended, to include: '*Plan / goal: establish medication efficacy and for Iris to receive most appropriate treatment with lease possible side effects … Action required: Iris to be given medication as prescribed. Any adverse side effects to be recorded and RMO to be advised. PRN medication to be offered as a last resort if distraction techniques, and ward activities not helping.'* **[p. 2, Care plan, 24 December 2013]**.

January 2014

90. On 2 January, the ward informed me that there would be a change of psychiatrist again, which I was unhappy about **[p. 16, DJ diary]**. By 7 January, mum had still not been seen by a psychiatrist and according to my handwritten notes the last she had been

seen by a psychiatrist at that point was on 27 December **[p. 16, DJ diary]**. I informed the ward that I was frustrated about this **[p. 16, DJ diary].**

91. On 9 January, I spoke to mum on the phone when I noticed that she was very agitated. I understood from her that this was partly because mum was going to have another change of psychiatrist. I also understood that her medication plan had changed at this point too, and she would be prescribed Lorazepam but not Diazepam **[pp. 17 – 18, DJ diary].** I understand that this is confirmed by NEPT's own medical records. On the phone, mum '*suggested that she could not carry on [and] that the staff were lying [and] trying to break her down.*'. I remember feeling at that point, as I went on to record in my handwritten notes, that there was something that mum was not telling me **[pp. 17 – 18, DJ diary].**

92. On 12 January, I visited mum when she told me that **she had taken to bed with her an everyday item that was nonetheless an obvious risk and** she had tried to suffocate herself with it because she did not want to be there anymore. I informed the staff about this **[pp. 19 – 20, DJ diary]**. I am not sure if the staff made a record of this disclosure at that point, but I understand that their records show that by 13 January my mum remained on Level 1 observations **[p. 40, NEPT Bundle 2]**.

The decision to rescind mum's section under the MHA

93. Mum's section under the MHA was due to end on 14 January and her clinicians decided not to extend this. Mum agreed to stay at the ward as a voluntary patient. I do not remember having any input into this decision, rather, we would have just been told that this decision had been made.

Mum's first ligature attempt

94. On 14 January, the same day that mum's section came to an end, she made her first ligature attempt.

95. Mum sustained major bruises to her face and dental injuries on this day. I understand that there do not appear to be any hospital records on this date to reflect the fact that mum had been injured on this date. We were not informed of mum's injuries or any accidents on this date.

Investigation of the ligature attempt

96. On 15 January, dad informed me that he had phoned the ward to see how mum was when he was told that she had gone for treatment because she had knocked her tooth out.

97. At around 16:30, I phoned the ward to speak to mum. Mum told me that she had had an accident. I questioned her about her accident. At first, she was very vague. After a lot of questioning, mum told me, *"I did it. I'm so sorry"*. I asked her what she meant by that and she responded, *"[I] tried to do away with myself – [I] don't want to be [here] – can't do it."* I asked her what she had done and she told me **[I/S] that she had attempted to ligature in her bathroom using a cord [I/S]** She said that the cord eventually broke and she woke up on the floor. This conversation is reflected in my handwritten notes from 15 January **[pp. 21 – 25, DJ diary].**

98. While mum was still on the phone with my dad, I called the ward using my mobile ON and I asked dad to keep mum talking on the phone. When I spoke to **[I/S]**, she told me that nothing was wrong and that I did not need to go to the ward. **[I/S]** said that what my mum told me was not true and that she was just attention-seeking.

99. My handwritten notes from this date specify the details of this call: *'I telephoned ward on my mobile [and] spoke to* **[I/S]** *who went to get her.* **[I/S]** *put me onto* **[I/S]** **[I/S]** *said mum story was not true [and] that mum was attention seeking. She said there had been an incident earlier in the evening [and] they had expected mum to do something to get attention. … She said that mum was trying to raise our anxiety.'.* **[pp. 21 – 25, DJ diary].**

100. I understand that NEPT's records confirm that **[I/S]** told me that *'this was not the case and staff are aware of Iris at all times due to her fluctuating levels of*

anxiety' **[p. 42, NEPT Bundle 3]**. I believe that [I/S] said this because she did not want me to go to the ward because of the extent of mum's injuries. At that point I thought to myself, *"what the hell are we dealing with?"*

101. I understand that mum was placed on Level 2 observations for 24 hours on 15 January **[pp. 41 – 42, NEPT Bundle 3].**

102. On 16 January, Dr [I/S] attended a ward review. I understand that the records show mum was still on Level 2 observations and had *'[a]ll risky objects … confiscated (any leads & cords)'* **[p. 3, Care Plan Progress Notes]**. I understand Dr [I/S] suggested a diagnosis of *'anxiety disorder with underlying personality traits'* and she suggested *'starting Risperidone as a small dose for anxiety and feelings of guilt'* **[p. 3, Care Plan Progress Notes]**.

103. On 16 January, dad and I visited the ward around 14:00. The first thing I noticed was the injuries to mum's face, and then she took me to her room to show me what she had done on 14 January. I asked if I could speak to [I/S] [I/S] took dad and I into a room and she explained that she did not think it was possible for mum to have attempted suicide because she was being observed every 20 minutes. [I/S] insisted that mum had fallen instead. I explained that mum had bruises to each side of her head, and I questioned how her dressing gown could have broken if it was not because of a ligature attempt. [I/S] suggested that mum must have cut the cord. I responded by saying that I had searched mum's room but had not come across any scissors. She then suggested that mum could have used the window ledge to have cut the cord. She was adamant that mum could not have attempted to ligature herself in a 20minute window. To that I said that it would only take one minute to do so. This is all reflected in my handwritten notes from this day **[pp. 26 – 32, DJ diary]**.

104. I phoned my brother Craig, who was at work, to come to the hospital. This shows how concerned I was because ordinarily I would never call him and take him away from work. He arrived at around 15:40. We approached mum's room when he arrived. It was dark in there. We could hear mum saying, *"No, no, no."* I opened the **door and we saw mum setting the cord up in the same way** again. Craig went to reception and asked the staff to come into mum's room. The staff were shocked. Mum's room was cleared. This is reflect in my handwritten notes **[pp. 26 – 32, DJ diary]**.

105. It was very concerning that there was a cord in mum's room on 16 January at around 15:40, despite our disclosure to them on 15 January that mum had attempted to ligature on 14 January. No one had searched her room to find the cord in light of that information. It was completely unacceptable that it was left for me, her daughter, to find the ligature myself in addition to facing the devastating news that mum could have died. I later came to learn that on 14 January, the only care that mum received following the incident was to be given some paracetamol and have her blood pressure measured.

106. Before leaving the ward, I informed the administrator at the desk, I think her name was [I/S], that I was not happy that the family had not been informed of the incident on 14 January and that going forward I wanted to be informed if any further incidents occurred, whether during the day or night **[p. 34, DJ diary]**.

107. I understand that NEPT's medical records indicate that the first time that mum had a physical examination by a doctor on the ward following the incident on 14 January, was at 19:00 on 16 January **[p. 6, Care Plan Progress Notes]**.

108. I understand that mum was kept on Level 2 observations and that she was not allowed into her room or to have any access to items that she might use to hurt herself with **[p. 46, NEPT Bundle 3]**.

109. I remained very concerned about the lack of investigation by the ward into our disclosures on 15 January. So, on 17 January, I contacted my independent advocate, **[I/S]** I informed him that I wanted to complain about the ward not informing us of mum's injuries, the lack of investigations surrounding it, and the failure to retrieve the cord from mum's room until 16 January when we, her children, discovered it ourselves. **[p. 36, DJ diary]**.

110. On 18 January, **[I/S]** informed me that he had gone to the ward and had been told that mum had had an accident by banging her head on the wall. I said to **[I/S]** that I wanted to obtain the night duty log from 14 January so I could see how the incident was recorded and the staffing numbers. **[I/S]** gave me the contact details for the Operations Service Manager **[I/S]** to request this from. I was told that **[I/S]** was off work and I was referred to the Clinical Manager, **[I/S]**, instead.

[I/S] called me at some point and I explained to her what I was unhappy about. [I/S] told me that they were short staffed around this time but that this was not my problem. Despite my efforts, I never obtained the night duty log using this avenue.

111. I visited mum at the ward on 18 January. This is the day that I took photographs of the bruises on her face which she sustained on 14 January. When I spoke to mum on this day, she told me some very concerning things. She said that she had not been getting any smiles from the staff anymore and that no one was talking to her – not even asking her about her eyes which were heavily bruised. Mum told me that when the ward manager had gone to see her on Friday, mum showed her what she had done in the bathroom and then the WM slammed the bathroom door, was very angry with her, and said to mum that she had '*really overstepped her boundaries [and] not to even ask about medication or anything'*. Mum said that staff had tried to get mum to change her account of 14 January. I made a record of these disclosures in my handwritten diary **[pp. 39 – 40, DJ diary]**. Mum also told me that at some point someone had said to her in the ward that if she did not change her story, then they were going to reveal something about her.

112. It was around this time that we got the sense as a family that the staff at the ward saw us as a nuisance. I say this because their facial expressions would change whenever they saw us approaching them. It was as though we were troublemakers. They would also make comments that suggested that "we run the ward, not you." Mum was concerned that if we asked the staff any questions then she would be the one getting the backlash. Mum kept asking us not to *"rock the boat"* and that they were *"not the same"* when we were not there. I think there was intimidating and verbal bullying going on. Craig and I discussed putting a camera in mum's room. We did not do this. Again, I wish we did because we would have a clearer idea of what was happening to mum.

113. Mum's risky behaviours continued to escalate this month. I understand that NEPT's records from 19 January show that mum had somehow succeeded in entering another patient's room and going through their belongings: '*Iris was then seen by HCA* [I/S] *to be in another patient's (PM) bedroom going through belongings. … Patient* [I/S] *later told HCA* [I/S] *that Iris had approached her and asked for dressing gown belt … Iris had asked fellow patient not to speak to staff. Datix completed'*. **[p. 53, NEPT Bundle 3]**.

114. On the same day, I spoke to mum on the phone and she told me that she was in trouble because she stole a dressing gown cord from another room and was caught. She told me that she could not do it anymore and did not want to be here. She said she could not help herself **[pp. 41 – 42, DJ diary]**. I do not know if the staff took any measures to investigate how she gained access to another patient's room when she was under observations and blocked from accessing her own room, and to update their risk assessment.

115. I understand that the records show that on this day, mum asked staff to give her PRN and Lorazepam but she was advised to *'let her regular medication take effect'* **[p. 52, NEPT Bundle 3]**.

116. On 20 January, I took mum to see her GP without telling the staff at the ward. I understand that the GP noted, '*Very agitated during consultation, pacing the room, walking into corner of room and huddling into corner behind couch, expressing concern about making things worse and worried about going back to the ward… Plan: Advised to speak with Crisis Team regarding taking back to ward due to the agitation Iris is expressing about going back. May be able to be seen at home.'* **[pp. 29 – 30, GP records]**.

117. On this visit, I remember that mum had asked for her wardrobe to be unlocked so that she could get her dirty clothes to be washed. I was horrified and devastated to discover a cord and a dressing gown belt in there. Especially considering the recent ligature attempt, her attempt to get another patient's risky items, and my complaint that her room had not been searched which meant that I had found a cord in her room on 16 January. I refused to leave the ward without this cord and it was mum's psychiatrist who allowed me to take it home **[pp. 51 – 52, DJ diary]**.

118. On this visit, mum raised more concerns about the staff which I made a record of in my diary: '*They are going to make my life hell. U don't know what its like in here. Its not all nice … otherwise they will break me. You can't beat the system Dawn. Tried to calm mum down. Talk to GP to see mums injuries [and] explain circumstances.'*. **[pp. 50 – 51, DJ Diary].** I remember her also saying at this point, *"I will have to change my story and say it was an accident".*

119. I understand that the SIR panel found that on 20 January, staff at the ward had observed mum place a bra in her pillowcase **[p. 27, SIR].** I do not remember any details about this.

120. On 22 January, I spoke to mum on the phone around 16:50, and I asked her if she had anyone come to check on her, but she was unsupervised. The reason that I asked this question was that mum was phoning me from outside of the ward.

CPA at the ward

121. On 23 January, Craig [I/S] dad and I attended a CPA meeting at the ward. This was attended by mum's consultant psychiatrist (Dr [I/S]), care coordinator ([I/S] [I/S]), nurse in charge ([I/S]) and the senior manager ([I/S]) **[pp. 7 – 8, Care Plan Progress Notes].**

122. At the CPA meeting, different issues were discussed including mum's medication, her lack of stimulation at the ward and safety issues. I expressed my concerns at the meeting that when I phoned the ward on 15 January to report her ligature attempt, I was told that mum was just attention-seeking, and in my view this was not investigated properly. I also explained to them that mum had told me that staff were trying to get her to change her story because she was spoiling the reputation of the ward. I told the ward that I was concerned about mum's care and that I had even considered perhaps moving her from this facility.

123. Craig told the staff at the meeting that had we have not attended the ward on 16 January and found mum re-enacting her ligature attempt, that we would not have been having this CPA meeting at all because the scene would have been cleared up and the staff would not have believed mum or us.

124. One of the staff members apologised and said that she would do everything in her power to make sure that this did not happen again. She said that she would speak to the ward and go through mum's management plan. The staff member also suggested that she would try to get their Occupational Therapist to spend some time with mum, and I understand that according to NEPT's records this happened on 28 January **[p. 76, NEPT Bundle 3].**

125. The staff asked us what we thought had changed in mum's circumstances that made her attempt to ligature. I responded to say that mum had wanted to do it before, but that she just did not have the courage to, whereas at this point she now had the will to go through with it.

126. During this meeting, Dr [I/S] then said that the team were not *"100% sure that it was an attempt"* on 14 January. She explained that they did not *"have clear evidence either way."* To this suggestion, we as the family said that we should not be hypothesising about the truth of what happened but that mum was in a very dark place and that the risk of self-harm was certainly there and that a plan was needed going forward with that in mind. Craig recorded this meeting.

127. On the same day, 23 January, spoke to mum and she told me that she could not live this way for the rest of her life and that she had wished that she was successful in her previous ligature attempt. She said that I should be careful as they would take things out on her.

128. In her own handwritten notes from this date, mum wrote, '…[I/S] *said I was rubbing my head to make it redder when she took me to the dentist. … She added they can only act on what had been reported and I have only reported to them I fell. .. Also all the redness plus swelling only came up on Thursday,. Be careful what you say. It will all backfire on me. Do not mention re the doctors or photos please. Because I will not know if they ask me and you have told them then I am in trouble again.'.* **[Iris Scott's notes].**

129. I understand that mum had *'her first session with psychologist* [I/S] on 23 January **[p. 62, NEPT Bundle 3].** I understand that on 24 January, mum reported that her medication was not working **[p. 9, Care Plan Progress Notes].** Mum told me that she did not want to be here anymore and wanted to end it all **[p. 62, DJ diary].** I understand thart the treatment plan was to increase her Risperidone dosage until her anxiety symptoms reduced **[p. 10, Care Plan Progress Notes].**

130. According to the statement that I produced for the inquest into mum's death, it was on 24 January that I was *'handed an envelope containing mum's belts. They said that they had searched her room and retrieved those'*. I do not understand where mum would have got these belts from and how she would have been able to obtain them if she was being observed effectively by staff.

February 2014

131. On 2 February, I spoke to mum on the phone when she revealed to me that after she asked a staff member called [I/S] to turn off the lights at nighttime, he said that he would leave it on all night if she kept asking them to turn the lights off **[p. 65, DJ diary].**

132. On the same day, I discovered on searching her jeans which I had collected from the ward to wash, that there was a pill in her jeans **[p. 65, DJ diary].** On 3 February, I spoke to [I/S] about this. [I/S] said that the pill did not sound like it was one of mum's and that she must have picked it up. If that is so, then I do not understand how mum was able to access medication that was not hers.

133. During this phone call, there was also confusion around what observation level mum was on. I queried what the observation level was because I found out, and I cannot remember how I found out, that mum had been able to use a staff card to access her own room and that her wardrobe door had been left unlocked **[pp. 66 – 67, DJ diary].**

134. I understand that NEPT's records show that mum's observation levels had been reduced from Level 2 to general **[p. 87, NEPT Bundle 3]**. On 4 February, I made a handwritten note in my diary that I was *'anxious now re mum not being on level 2 obs (sic)'* **[p. 68, DJ Diary].**

135. Mum continued to express concerns about her medication. On 6 February, I understand that mum was reported to have said that she could not continue like this and that she needed her medications changed **[p. 11, Care Plan Progress Notes].**

136. I understand that these concerns were discussed with us on 11 February when her psychologist, [I/S] said that *'medication only appeared to be effective last time however there appears to be more psychological issues this time.'* **[pp. 116 – 117, NEPT Bundle 3].** Craig and I expressed our concerns to the team that it seemed that they were trying to find the root cause for mum's presentation, rather than treating the presentation in front of them. We asked for mum to be sedated and we asked for her to be placed on the same treatment plan that she was on in 2007 or 2008. Ultimately, we were told that this was not possible and that we needed to speak to her psychiatrist **[pp. 69 – 71, DJ diary].**

137. I understand that the medical records show that on 11 February, mum's notes listed the following medications: Atorvastatin, Zopiclone, Diazepam, Pregabalin, Mirtazapine, Lorazepam and Risperidone **[Medication Chart]**. I do not know if this means that she was taking all of this medication at this time.

138. On 11 February, we also discussed mum's bedroom access. I understand that NEPT's records state that [I/S] *explained that this is dependent on how Iris presents at any one time, it is not about mixed messages, and staff have to make decisions based on what they see and are aware of'* **[p. 118, NEPT Bundle 3].**

139. I understand that the records state that on this day, mum approached the staff and asked them if she was allowed to have private telephone calls. In response, it was explained to her by staff that *'following her behaviour during her husband and daughter's visit the previous day it was felt necessary to monitor conversations with her family'* **[p. 120, NEPT Bundle 3].** I was not informed of this decision. I only learned of this following my legal team's review of the records in response to the Inquiry's Rule 9. I am appalled by this and I had the same suspicions about our telephone conversations being listened to by staff, back on 24th December 2013.

140. I understand that my mum's diagnosis was questioned again on 19 February. I understand that NEPT's records state that there was *'[s]ome debate as to whether [Iris] has a genuine mental illness or personality problems and control'* **[p. 109, NEPT Bundle 2].**

141. On 20 February, I understand that mum's medication plan changed with an increase in her Risperidone dose and her Lorazepam stopped **[p. 14, Care Plan Progress Notes]**. [I/S] statement notes that *'the nursing staff [reported] that she … had deteriorated since the [R]isperidone was increased'* **[§14, [I/S] witness statement, 2015].** I understand that Dr [I/S] rationale for this was that *'it would be important to give her current medication ([R]isperidone) a trial period, and that the dose needed to be optimised, and changing it to another medication at such an early stage was not going to be beneficial'* **[§14, [I/S] witness statement, 2015].**

142. I understand that a psychologist's report dated 28 February 2014 and authored by Dr [I/S] notes that in the week of 24 February, she attempted to meet mum

three times but that mum was '*preoccupied with other ideas, such as changing her medication'* **[p. 129, NEPT Bundle 1].**

27 February 2014 – 1 March 2014

The decision to take mum off restrictions

143. On 28 February, I was informed by [I/S] at around 09:00 that mum had been taken off restrictions, meaning that she would have access to her wardrobe and items which were previously deemed too risky **[p. 75, DJ diary].** When I was told this, I asked [I/S] how the risk was assessed and I was told that Dr [I/S] who was not mum's named doctor, had spoken to mum and was happy that she no longer had any suicidal thoughts. I asked [I/S] if Dr [I/S] knew about this and [I/S] confirmed that she did, but that she had been called out **[p. 75, DJ diary].**

144. Although I was informed of this decision on the morning of 28 February, I understand that NEPT's records show that this decision had in fact been made on 27 February. NEPT's records show the rationale behind this decision, and the Inquiry will note that some of the entries contradict each other:

a. Prior to the ward review on 27 February, Dr [I/S] had explained that she had spoken to the nursing staff and care coordinator [I/S] that if *'there were of the overall opinion that Mrs Scott had improved … and that if there were no other concerns (raised during the ward review) then the plan was to remove the restrictions on the ward'* **[§15 [I/S] witness statement, 2015].**

b. *'Iris reported not to feel any improvement that she knew she was not better despite staff feeling she was significantly so. Iris feels her medication is not settling her and is not right for her. Iris denied feeling calmer and lacked confidence to reassure* [I/S] *that she would not exhibit risk behaviours in* [I/S] *car on leave.* [I/S] *clarified that she could be no changes in the plan then. Iris reported to feel better on the ward and CN* [I/S] *explained that without Iris having confidence to control her behaviour, staff could not be reassured enough to life restrictions to her bedspace and risk items' … 'Iris was able to reassure staff that she would not behave inappropriate or in a dangerous manner with her items should ward restrictions be lifted. Brief risk assessment completed … Iris reported she would not know what*

to do with her risk items even if she wanted to do something with them. She reported that thoughts of her family stop her from exhibiting any risk to herself.'. **[p. 154, NEPT Bundle 3].**

c. *'Mrs Scott was then invited in, and we discussed our findings. She reported that in spite of this evidence she was not feeling well and felt that she had not improved. She tried to steer the discussion towards medications; that the medications were not helping to calm her.' .. 'She said that she would not behave inappropriately or in a dangerous manner with her items' … 'She repeatedly denied any suicidal ideation, and reported that her family were a protective factor.'.* **[§§19 – 22, [I/S] [I/S] witness statement, 2015].**

145. Dr **[I/S]** authorised the lifting of restrictions only if no further concerns were raised during the ward review on 27 February and that things had improved up to this point, but at this ward review mum had expressed that she had not improved and did not feel she could remain calm if Ann were to take her in the car.

146. Staff seemed to rely on mum saying to them that she would not even know how to use her risky items. Mum had already shown that she knew how to ligature using her clothing, hence the incident on 14 January and the subsequent attempts she made to steal other patient's items. On 15 February, I understand that Craig had left mum an i-Pod but that with the it *'was agreed that the earphones would be retained by ward staff due to potential risk of Iris self-harm[ing]',* implying that the staff then considered that mum would have known how to self-harm using earphones **[p. 120, NEPT Bundle 3].**

147. The staff seemed to rely on mum saying that the thoughts of her family would stop her from hurting herself. I understand that on 13 February mum told them *'that she didn't have feelings for her family and that she did not miss her grandchildren.'* **[§12, [I/S] witness statement, undated].**

148. I do not know if the doctor that was standing in place for Dr **[I/S]** was aware of this history when they made the decision to allow mum to access her personal belongings, including risky items, without supervision.

<u>Circumstances leading to mum's death</u>

149. Mum was alleged to have been found hanging at around 00:15 on **1 March 2014**. To give context to the staffing levels and general environment in the hours before mum's death, I understand that NEPT's records from 22:00 on 28 February 2014 state that *'[o]nly 1 female on Ruby ward … agreed to scoop 1 female from Linchingfield and 1 male on Topaz. … On (sic) Litchingfield client had been found using drugs, S/B Dr and now absconded over the fence. Missings person procedure being implemented. (sic)'* **[p. 105, NEPT Bundle 1].**

150. **[I/S]** is the individual that is said to have found mum hanging. He provided a statement to the inquest into mum's death, which outlined his version of events from those early hours. In that statement, I understand that **[I/S]** outlined his version of events about the hours leading up to mum's death. He said that he started work around 20:30, had a handover with the late shift staff when he was informed that mum had taken PRN medication because she was feeling anxious (I did not know about this until my legal team's review of the records and question whether this raised alarm bells for **[I/S]** given my mum's previous self-harm attempt), and he was working that shift with staff nurses **[I/S]** and **[I/S]** [**[I/S]** **police witness statement, 1 March 2014].**

151. I understand that **[I/S]** said in his statement that he had '*recently been informed that Iris had confided in another patient that she had feelings she wanted to kill herself so she was moved up to a level two, this means she was on more checks and we watch her more often. Iris had been placed back onto general observations'*, and that he said in his statement that on, '*[a]ll staff take it in turns to do the checks on patients every hour'*.

152. I believe that when mum was given her medication that evening, she had told the staff that she did not need to be checked on – I believe that this should have been another alarm bell for the staff.

153. In a follow up statement for the inquest dated 8 March 2014, I understand that **[I/S]** clarified that *I believe that Iris was actually checked by my colleague* **[I/S]** *at midnight and she informed me that Iris had been in bed and all in order. … The check that I performed at 00:15 … was an additional check that I decided to make due to the fact that Iris had only recently come off level 2 observations and I wanted to ensure she was ok.'*

154. I will always doubt that these observations ever took place as they were said to, but I have no proof that this did not happen because I was not there. I recall that the PAC Tag Report that we eventually received from NEPT showed that mum's room was not in accessed until 00:26 on 1 March 2014.

155. I understand that in his statement, **[I/S]** stated that it was on the check he claims to have done *'at about 00:15'* that he found mum hanging *'from the bathroom door by a scarf'*. The first point to raise is that the scarf that she was said to be found with was hers. She must have taken it back to the ward with her after one of her home visits. This should have been identified on a search and locked away in her wardrobe. I still question how she could have ligatured using this scarf. Was it even long enough to tie to the bathroom door and around her neck, and to then hold her weight, given how thin it was? **[I/S]** said that mum had been found **in a particular position**, but this would not have been possible given the length of the scarf. When I saw mum at the mortuary at 09:30am on 1 March 2014, she did not have any ligature marks around her neck.

156. **[I/S]** said in his statement that when he found mum, *'there was a chair close to the bathroom door' and 'marks … on her neck'*. From my recollection though, there was only one big chair in mum's room. It was heavy and it would have made a noise if she had dragged it across the floor towards the door of the toilet in those early hours.

157. Even though **[I/S]** claims to have identified mum hanging at 00:15, I understand that the East of England Ambulance Service's records show that they were first called at 00:32:51, and at 00:35:09 it was confirmed that the ward had a defibrillator **[EEAS, EPCR]**. The ambulance records from 00:36:09 show that *'caller is not with the patient'*. I think that this was because the phone that Mr **[I/S]** used to contact 999 was not cordless and was based in a different location, so he was not able to attend to my mum at the same time as being on the phone to the call operator. I understand that the ambulance crew arrived at 00:38:12 and a record was made at 00:43:04 that *'[t]his is a workable arrest'. I understand that EEAS' records show that an entry was made at 02:17:38 stating, '[patient] deceased.'* The SIR notes that mum died at 01:21. I was, until the point that my legal team reviewed the records for this Rule 9 request, under the impression that mum died before 02:00.

158. I am not clear on why it took so long for the ambulance to be called, whether the staff were properly trained on how to use the defibrillator and to do mum's chest compressions,

why it took so long for the on-call doctor to arrive by mum's side, or why mum died even though it is noted that she was in a workable cardiac arrest. I understood from the doctor that they did not know that it was an emergency.

159. I still do not understand how mum died. These unanswered questions about how mum died still haunt me. If mum did die as the ward staff claim she did, then mum took her own life in the exactly the same way that she had ligatured on 14 January 2014, which I understand is described by NEPT's in their own records from 26 January as, '*she had used her dressing gown belt tied over the bathroom door.*' **[p. 289, NEPT Bundle 3]**.

160. I know that in the week leading up to mum's death, she was asking for PRN medication and for blood tests. She felt like she had been made to go cold turkey and that something was not right with her medication. What hurts me the most is that in mum's last week of life, she was crying out for help, but she was not getting it from anyone.

After death

161. On 1 March 2014 when I attended the ward, there was no coherent process in place. It was very haphazard. None of the staff appeared to know the procedure. They did not even have the number for the mortuary. The staff kept on referring to mum as "*the body*" in front of us. After attending the ward, I made a journal entry stating: *'Nurse said twice about going to see "the body"'* **[pp. 84 – 88, DJ diary]**.

162. I went to the mortuary to see mum at around 09:30am on 1 March 2014 **[p. 88, DJ diary]**.

163. On 2 March 2014, we went back to the ward to collect mum's belongings from her room. As outlined in my witness statement for the inquest in 2015, *'I was shocked to find knitting needles in my mum's wardrobe. Mum was a keen knitter but surely they should have been removed along with the belts.'*.

Quality of investigations undertaken or commissioned by healthcare providers

164. On 11 March 2014, my husband **[I/S]** e-mailed NEPT to inform that we would be complaining about them. He outlined our main concerns as being her *'[t]reatment whilst [an] inpatient, [the m]anner in which her attempted suicide was dealt with, '[the p]rocess which accessed her as no longer [a] suicide risk less than 24 hours before she took her own life'*.

165. NEPT responded to this on 12 March 2014 stating that they *would 'handle any issues that the family raise openly and promptly'* and that the issues which **my husband raised would** *'form part of the investigation which [was] underway and [they would] invite [us] to contribute [our] views to this.'*.

166. On 20 March 2014, NEPT sent me a letter explaining that they would be investigating mum's death and enclosing an information booklet. Mum's funeral was on 31 March 2014 and I think it was on this day that I received a phone call from NEPT. Given that this was the day of mum's funeral and the day after Mother's Day, I did not want to engage with NEPT.

167. On 21 May 2014, I received a letter from NEPT stating that they had '*completed a panel investigation […consisting] of a Consultant psychiatrist, a Dementia Nurse and Clinical Manager (sic) – all from the East/West area of the Trust' and that they would 'be in a position to share this report and its findings … prior to the inquest.'*.

168. I was dismissive of the SIR process from the start because this was an investigation that was done in-house. I remember that there was a delay in evidence gathering, even though you would expect statements to be taken within the first few days of a death. I understand that the female nurse on duty that evening did not make a statement until 6th May 2014. This being a Serious Incident Report, the clue was in the name.

169. My overall view of the SIR that took place following mum's death and the report that was produced on 8 June 2014 is that it was a cut and paste job. I assume that NEPT use a pro forma for everyone, just filling in the gaps where there are any. To illustrate this point, the SIR referred to mum as, '*Mrs Smith'*. This was very disappointing to see.

170. I do not think that the SIR identified all the key issues in mum's case. To provide some examples of such issues, I do not think that the SIR sufficiently addressed the issues

surrounding the PAC Tag report; or how staff dealt with mum's cardiac arrest; or that when mum needed help, no one there knew how to respond; or that there were ligature points.

171. On 21 July 2014, just over a month after NEPT had produced their SIR, NEPT wrote to my father to apologise for sending out a letter addressed to mum, when she had already died, inviting her *'to become more involved in [the] NHS Foundation Trust by standing for [their] Council of Governors'*.

Observations on Dr Milind Karale's evidence

172. I understand the Dr Karale has provided two statements to the Inquiry and has also provided evidence in the April to May 2025 hearings. I would assume that the standards outlined by Dr Karale would have applied in one way or another to NEPT between June 2013 when mum had her first appointment with them and 1 March 2014 when she died. I do not believe that mum's assessments, observations, treatment plans and care plans as an inpatient met adequate standards.

Other investigations or legal proceedings

Inquest

173. On 3 March 2014, I spoke with the local coroner and I informed him that I was not happy with the timeline of the investigation. The coroner opened an inquest into mum's death. I knew I would need legal representation and I think I found INQUEST through my own research rather than anyone from NEPT telling me about this service. In the end, my family had to fund the legal representation privately at the start.

174. In September, October and December 2014, I asked NEPT to provide me with their keycard logs (PAC Tag report) showing where and when staff keycards were used on the night mum died.

175. On 8 December 2014, I e-mailed **[I/S]** at NEPT expressing: *In October I wrote to the trust requesting the PAC Tag report from the night of my mother's death. … I have not had any contact with the trust in respect of my request. [… the coroner's office] are not in possession of information that I feel is crucial to the sequence of events on that night shift. I understand from the SIR that only one member of staff had a PAC tag for*

entry into my mums room and therefore I cannot understand the delay in supplying this information especially as my brother and I requested the information verbally in a meeting with yourself and [I/S] *on the 15th September and also on the phone.'*.

176. I received an e-mail response from [I/S] on 15 December 2014, stating: *'It was agreed at the meeting that you both would put your concerns in writing with regards to the SI report and any further requests for information. As I have not received a written response, I have been unable to action any of your concerns'*.

177. I replied to this by e-mail on 18 December 2014, stating, *"To clarify I did write to the trust in October after one of our conversations however I failed to send it in recorded delivery'*.

178. The inquest was supposed to go ahead in early March 2015. On 2 March 2015, my solicitor wrote to the coroner's court to complain that we had not been made aware of any coronial directions, that jury bundles had still not been agreed, and that no formal disclosure process had taken place.

179. On 3 March 2015, the coroner agreed to adjourn the inquest because of the disclosure problems.

180. The final hearing of the inquest eventually took place between 9 to 12 June 2015. Although the investigation was supposed to be independent, it felt to me that the process leant more towards NEPT.

181. For example, the coroner insisted that evidence relating to mum's private personal issue from years ago was an issue that had to be explored at the inquest. This decision by the coroner to discuss mum's private personal issue in open court, which we did not think was necessary and which I remember NEPT said was also not necessary to explore, broke my dad's world.

182. Another example is that as a family we were not allowed to present some evidence and were told that this was an inquest not a police investigation. We were very concerned for example that NEPT's statements about the staff's whereabouts on 28 February 2013 to 1 March 2013 did not add up with the electronic keycard logs.

183. NEPT claimed that [I/S], could not be traced for the inquest - but I understand that he was in fact at that time still working for NEPT. [I/S] gave evidence to this fact at the inquest.

184. In the end, the jury found that mum's medical cause of death was '1a suspension' and delivering a conclusion of 'Suicide'. The coroner did not issue a Prevention of Future Deaths report. With the number of deaths in the same hospital at the time, I question why the coroner was not raising any issues. Overall, the inquest process was not a pleasant experience for me as a bereaved daughter.

185. We had asked for a full toxicology to take place at mum's post-mortem because in mum's personal diary she stated twice in her last week that she wanted a blood test and PRN because she felt awful and that if she knew what withdrawal felt like that is how it would have seemed. We had also found out that NEPT had provided the wrong details to the doctor carrying out mum's post-mortem. I believe this was in the witness statement of PC [I/S] when he made reference to being handed the wrong notes for mum's postmortem, and I think this is noted in the post-mortem, and I have not located these documents or provided my legal team with them. I think that the pathology report made reference to the fact that Risperidone levels were low.

Civil claim

186. After the inquest, Craig and I took legal action against NEPT for their negligent care and treatment of mum. This was settled but with no admission of liability. I wanted NEPT to stand up and be accountable to us. I wanted NEPT to express some remorse for the things that happened and to assure us that they would make changes.

Further NEPT contact

187. On 21 March 2016, the Interim Associate Director of Quality in the Patient Safety and Complaints Team, [I/S], e-mailed me to ask me if I would be happy to meet with him to discuss any questions I had. On 16 June 2016, I responded to [I/S] stating that I had identified further issues that I wanted to discuss with him and that I would accept a visit to Ruby Ward. I remember going to a meeting but I do not remember any of the details and I do not remember ever going back to the ward.

My views and recommendations for change

188. In my experience, there was nothing positive about mum's treatment or care at NEPT. Those were six very dark months.

189. The Inquiry asks what I think should have been done differently in my mum's case. Everything should have been done differently. It all went wrong from the start when we attended mum's first appointment in June 2013. They should have listened to us as a family and repeated the actions of the crisis team from years back. Mum should have never gone into this ward where her mental health was left to escalate.

190. The Inquiry has asked for my recommendations for change. I consider that the following areas need to be looked into and improved:

a. Staffing and training
b. Suitability of wards (assessed on clinical need not age)
c. Interaction with and between staff and psychiatrists regarding care plans and treatmen
d. Compliance with CQC and other regulatory body recommendations

Statement of truth:

I believe the contents of this statement to be true.

[I/S]

Name: DAWN JOHNSON

Date: 9th June 2025.

ANNEX OF EXHIBITS

ACCOMPANYING THE WITNESS STATEMENT OF DAWN JOHNSON

PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

DOCUMENT	EXHIBIT REFERENCE
NEPT Records – Bundle 1	**DJ/1**
NEPT Records – Bundle 2	**DJ/2**
NEPT Records – Bundle 3	**DJ/3**
Care plan – 24 December 2013	**DJ/3A**
NEPT Care Plan Progress Notes handwritten	**DJ/3B**
NEPT meeting minutes – 11 February 2014	**DJ/4**
NEPT medication chart	**DJ/5**
GP Records	**DJ/6**
Iris Scott's handwritten diary 2013 diary	**DJ/7**
Iris Scott's handwritten notes	**DJ/8**
Dawn Johnson's handwritten diary	**DJ/9**
Iris Scott's facial photographs taken by Dawn Johnson on 18 January 2014	**DJ/10**
Photograph of **[I/S]** that mum ligatured with on 14 January 2014; and photograph of **[I/S]** that mum allegedly ligatured with on 28 February 2014 - 1 March 2014	**DJ/11**
East of England Ambulance Service EPCR	**DJ/12**

Inquest Witness Statements Bundle	**DJ/13**
[I/S] Witness Statement, 2015 (Key Worker)	**DJ/13A**
Dr [I/S] Witness Statement, undated (Psychiatry doctor)	**DJ/13B**
[I/S] Witness Statements x2 1 March 2014 8 March 2014 (Healthcare assistant)	**D/13C** **DJ/13D**
Dawn Johnson's Witness Statement 2015	**DJ/14**
NEPT letter to Iris inviting her to join the Board of Governors July 2014	**DJ/15**
[I/S] (Dawn Johnson's husband) e-mail to NEPT 11 March 2014	**DJ/16**
NEPT response to [Dawn Johnson's husband] 12 March 2014	**DJ/17**
NEPT letter to Dawn Johnson 20 March 2014	**DJ/18**
NEPT letter to Dawn Johnson 21 May 2014	**DJ/19**
Dawn Johnson email to NEPT 8 December 2014	**DJ/20**
NEPT response to Dawn Johnson 15 December 2014	**DJ/21**

Dawn Johnson email to NEPT 18 December 2014	**DJ/22**
Email correspondence with [I/S] [I/S] Associate Director of Quality in the Patient Safety and Complaints Team, NEPT, 21 March 2016 and 16 June 2016	**DJ/23**