WITNESS STATEMENT OF EMMA HARLEY, PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. **I, Emma Harley am the sister of the late Terence White (born on 13.02.1983; died on 14.04.2019.)**

2. I am making this statement based on my memory of events, from having seen / from my understanding of what my late brother's records / other disclosure states.

3. I reserve the right to make a supplementary statement based on further disclosure which is obtained.

Background information

4. The Root Cause Analysis Investigation Report prepared by Essex Partnership University Trust Foundation Trust dated May 2019 ("RCA report") states:

> *"Mr W was a 36 year old father of two,* **[I/S]** **[I/S]** *who had struggled with substance misuse throughout his adult life and suffered from anxiety and depression with a history of overdoses. Historically he had a diagnosis of ADHD in his teens.*
>
> *The patient lived alone in the Basildon area and had moved there in the 18 months before his death. At the time of his death he was in a relationship and had regular contact with his partner. Mr W maintained regular contact with his youngest child; however he had not seen his elder daughter since 2017.*
>
> *Mr W had been unemployed for a number of years before the incident, however prior to this he had worked various jobs including block paving, landscape gardening, gas central heating and preparing exhibitions for the Tate Art Gallery.*

He reported he was the main carer to his father who lived in Colchester who was terminally ill and had physical and mental health difficulties.

He was born in Rush Green in London and was brought up in Romford until he was around 7 years old when he moved to Chelmsford with his mother and step-father. **[I/S]** **[I/S]** *History provided by the patient in his records indicate that depression ran in the patients family; his mother was severely depressed and died in 2016 of terminal cancer and his aunt committed suicide 8 years ago. Records indicate a diagnosis of ADHD at age 17.*

Mr W's documented physical health information detailed that at the age of approximately 18 months he accidently set fire to himself having obtained a box of matches which resulted in skin grafts. He was reportedly deaf until the age of 4 when he had grommets fitted. He was bullied at school and missed school as a result of this. He had also undergone a hernia repair, appendectomy, a repair to a damaged optic nerve and had a metal/titanium plate on his cheekbone, although it is unclear from records held at what ages these procedures were undertaken."

Summary with regards to Terry's mental health

5. The following is from the RCA report :

The RCA report uses abbreviations which the report explains as follows:

"RAID Rapid Assessment, Intervention and Discharge Team"

"CJDLT Criminal Justice Liaison and Diversion Team"

"FRT First Response Team"

"NELFT North East London Foundation Trust"

The RCA report states:

"Mr W had periodically accessed mental health services and community drug and alcohol services between 2000 and 2008 within North Essex Partnership University Trust; this was prior to the merger with South Essex Partnership University Trust when Essex

Partnership University NHS Foundation Trust was created in April 2017."

There was no contact then with Trust services until October 2016 when Mr W had periodic contact with the RAID team, CJLDT and FRT. In 2018 he was under the care of NELFT and had been seen by HAABIT on two occasions (Havering Access and Assessment, Brief Intervention Team) as his GP was in Upminster, and had a further planned follow up in Jan 2019.

At the time of the incident Mr W was awaiting assessment with FRT following a referral received from his GP on 18th March 2019 and was not being seen by any other Trust services. The GP advised that at the time of the referral he was prescribed Diazepam and Pregabalin.

The Trust were notified by the Coroner on 15th April that Mr W had been found hanging at his home address on 14th April 2019 prior to his scheduled FRT assessment appointment on 17th April 2019."

6. **Chronology of events**

I have enclosed below a chronology according to the RCA report, medical records and other disclosure which I have. I have also enclosed my comments regarding these entries. In my view the failings into my brother's care stem from the following lines which are in a document (which is further discussed below) which is entitled the "*Questions from Report on Terry White*":

"Terry didn't understand his mental health needs and taking drugs was a way of self medicating. The focus was on his drug taking and not on his mental health"

2016

7. **10 October 2016**

The medical records state:

"… Basildon and Thurrock University Hospitals NHS Foundation Trust…

10 Oct 2016 05:47…

…pt took **overdose**

[I/S] *had large family stresses…"*

8. **11 October 2016**

The medical records state:

"…Hx smoking cannabis … had 2 lines cocaine last week…"

9. **Letter in the medical records dated 21 October 2016**

Letter states:

"… Psychiatric Liaison Service Mental Health Unit Basildon Hospital…

Assessment Date: 11.10.2016

Thank you for referring terry to the RAID Team. Terry was admitted following a mixed overdose which he claims at the time was taken with suicidal intent. He now regrets his actions. He said "it was an impulsive act done out of frustration because so many things happened within a short space of time and it all just got on top of me …."

Clinical Impression:

Impulsive Overdose. Terry does not feel he needs any input from MH services. Would like some help with his ADHA.

Management Plan:

- *Discharge from RAID.*
- *Refer to GP for referral for management of ADHD.*
- *Partner to ensure compliance with medication. (Terry did not feel the need for his Sertraline to be reviewed at present. He feels he is well when he takes this regularly)*
- *Crisis number/information given …*

Psychiatric Liaison Nurse …"

2017

10. **3 December 2017**

The medical records state:

"… Basildon and Thurrock University Hospitals NHS Foundation Trust…
03-Dec-2017 00:00…
… presented following an overdose of **[I/S]** *…*
He is Medically fit for discharge, and due to be seen by the mental health team."

The following entries are unclear, but appear to state:

"03/12/17 … Patient managed to open drug cupboard despite being locked*…*
Family (sister and friend) were in ward complaining that patient shouldn't have his medications by his bedside. But I didn't realize that patient managed to break cupboard. Patient accepted that he managed to break open cupboard…"

"… 03/12/17 Nursing (sister in charge)
Patient's sister and a friend….(illegible..)concerns regarding patient. They said that he can become very aggressive and he texted them that once is out of the hospital he is …(illegible) to self harm…"

"03/12/17 19:50
…Family worried about Patient getting self discharged. Will need MCA 2 + DOLS if patient attempts to self discharge, as high risk of suicidal ideations."

11. **5th December 2017**

12. The medical records state:

"Essex Partnership University NHS Foundation Trust…
… intentional overdose **[I/S]** **[I/S]** *background history of depression, prescribed Sertraline via GP; no current contact with our service. He consented to RAID assessment and for staff to speak on phone to his sister Emma…*
Overdose was impulsive; …He felt fed up about things that have been going on his life…

Now saying he regrets the overdose
No active or further suicidal thoughts, plans or intentions… Wishes to be told what his diagnosis is, wonders whether his ADHD is turning into Bi Polar…Still registered with a GP in Upminster where he lived before…

Not currently open to our service
Previously seen by RAID on 11/10/16 following an impulsive mixed overdose
Prescribed Sertraline by GP last year, said he has not had this since this hospital admission…

Drugs – denies recent use
Cannabis- said he uses this now and then as it helps calm him down
Said he last used this few weeks ago
Cocaine – reports he last used this 3months ago after being a heavy user for years..Said he stopped using this himself
Non-prescribed Diazepam for 2weeks prior to admission, also used Oramorph..Stated these were give to him by a friend and he has no longer has any more left…

Sometimes gets OCD thoughts and obsessions about cleanliness and germs…History of taking overdoses, **[I/S]** **[I/S]** *prior to this admission; mixed overdose in October 2016 ; history of cocaine and cannabis use as well as using non prescribed medication which he got from a friend no other suicidal behaviours or attempts reported…"*

Next to "*Accidental self-harm…",* "Yes" is indicated. It then states "*Risk likely to be increased by impulsive behaviour, illicit substance use and poor coping skills…"*

Next to *"Risk of violence and / or aggression / harm to others…",* "Yes" is indicated. It then states *"No current issues reported or evident*
History of getting angry and agitated and getting into fights
Sister reports history of being in fights; hit his ex- partner's father 2months ago following an alleged altercation
History of involvement in gangs
reported by sister"

"…Sister reports history of not attending appointments offered in the past…"
"Sister Emma reported the following: …
Things have built up from when he was a child, diagnosed ADHD at 16yr..It's been a long battle to find out what is wrong; he keeps

slipping the net… did not attend appointment offered to see a psychiatrist. He has been self medicating all his life
He tells lies at times and is not always honest with her re drug use and what he is up to

she has previously got random phone call from him when has sounded "delusional" and seeming to have a "psychotic episode" he has been under the influence of drugs at these times
He seems to "blame everyone and it is all about him"
He can be alright for some weeks and seem normal for 2-3weeks, but then this can change

She feels he is presenting as alright as the drugs are out of his system, but this may change when he uses drugs
She said he has also been self medicating with non-prescribed Diazepam as weel as using weed and cocaine
She stated that he has said to her that he intended to end his life when he took the tablets but is now saying he wants to be on the right tablets and be better

She also said whilst in hospital she has been told by his friend that he was asking for friend to bring him in some weed as well as talking about "bringing the metal out" to deal with ? someone with whom some money is owed..He has been involved in gangs and sometimes gets into fights or unprovoked attacks

She said she worries that he may end up doing something and cause harm to himself or others…

Sister reported that it is impacting on her and their brother
She feels he need some sort of support as this has been going on for a while and spoke of the previous overdose he took last year…

Patient declined needing admission as feels he can keep himself safe and wants to go home…

"I want professional help"
"to speak to a doctor who can diagnose me and tell me what is wrong. I think my ADHD is turning into Bi Polar"

"I don't want to be admitted or anything like that. I need tablets to help keep my mood at a level. To live a normal life and not have my mood going up and down"

Discussed with Dr **[I/S]** *and plan agreed…*
AMU East ward doctor advised to consider re-starting Sertraline as prescribed if no medical concerns…

Ward doctor also informed about the limping, pain and numbness in legs which patient has reported.

Discharged from RAID
RAID to refer to IAPT
RAID to refer to First Response Team to be consider urgently for medical review
Given contact details for our service as well as details for bereavement service and drug and alcohol service…"

"*Basildon and Thurrock University Hospitals …*
05/12/17 1552 …

RAID – Mental health liaison …

attended to see patient. Spoke to his sister Emma for collateral history with consent from patient …

He denied active or further thoughts to end his life…had intention to end his life when he impulsively took overdose…would like for his medication to be looked at regarding his mood…

diagnosed with ADHD when he was 17 yrs and now wonders whether this has turned into something else now … prescribed sertraline …

discussed with Dr **[I/S]** *(RAID Consultant) …*
…RAID have discussed with AMU – East Dr **[I/S]** *who referred the patient. No medical reason for stopping sertraline..identify..*

- *Discharged from RAID liaison …*
- *RAID to refer patient to First Response Team to request medical review in the community …*
- *He can self-refer to drug services … informed him about bereavement counselling …*
  ..RAID to refer patient to IAPT for assessment / consideration for therapy …
- *… contact GP …*
- *patient's next of kin also…"*

13. **6th December 2017**

The medical records state:

"Essex Partnership University NHS Foundation Trust …
Email sent on 06/12/2017 stating..

'…Please can the above patient be referred to FRT for urgent medical review and IAPT…"

14. **Letter dated 17th December 2017 which states :**

"*Essex Partnership University NHS Foundation Trust … RAID Psychiatric Liason Team*
Assessment date : 04.12.2017

Terry presented to Basildon A&E after taking an overdose. RAID were asked to assess. … he had intention to end his life when he impulsively took the overdose … social/personally stressors … bereavement and family issues…

He now says he regrets taking the overdose … thoughts of his daughter are protective factors for him. …

States he was diagnosed with ADHD when he was 17 yrs old and now wonders whether this has turned into something else now. He is prescribed Sertraline by GP and last took this prior to hospital admission. …
….discussed with Dr **[I/S]** *(RAID consultant) and following plan agreed.*

- *RAID have discussed with AMU East Dr* **[I/S]** *who referred the patient. No medical reason for stripping Sertraline identified. She agreed this can be re-started*
- *Patient has been deemed to be medically fit for discharge*
- *RAID have informed ward Dr re patients complaints re pain, numbness and bruise marks and he has reported (on both lower legs). He suspects it happened following the overdose and it's also reported that he had a fall.*
- *Discharged from RAID*
- *RAID request GP to request secondary services and IAPT input if he feels this is needed*
- *GP to advise patient to register with GP in local area*
- *Patient given contact details for our services, he has also been made aware that he can self-refer to drug services if he feels he had problems, re illicit drug user, also informed him about bereavement counselling*
- *Contingency plan discussed should there be deterioration in future, to contact GP, our service or to attend A&E in emergency*
- *Patients next of kin also made aware of the plan and how to access service if there are any concerns*"

15. **23rd December 2017**

The medical records state :

"*Essex Partnership University NHS Foundation Trust …*

Terence was seen by street triage today after he contacted his brother informing the brother that he was having suicidal thoughts.
Attending police attended the scene and found the front door to be open. he had planned to electrocute himself whilst in the bath [I/S] [I/S] *On arrival Terrence was rather tearful - he was breathalysed and blew 0.38. He admitted to have smoked cannabis which was evident whilst in the flat.*

Terence had been discharged 17th Dec 2017 from RAID following an overdose and a plan had been put in place for Terence to self refer if required to drug and alcohol services, to register at a local GP and provided emergency numbers should he require them. However when I asked Terence about the plan he has not done anything to date.
Terence said his thoughts suicide were impulsive and he no longer had any thoughts to harm himself or others.

He agreed to make contact with the drug and alcohol service and i provided him telephone numbers …which he stored on to his mobile phone should he require any telephone advice or support from mental health services and refer to IHAP/bereavement.

Attending police let the water out of the bath [I/S] [I/S] *Terence's girlfriend* [I/S] *"is due to attend the flat later in the afternoon which was confirmed in our presence over the telephone.*

2018

16. **4 January 2018**

The medical records state :

Letter from "*Essex Partnership University NHS Foundation Trust, Street Triage service…*
4 January 2018 …
Date of Assessment: 23rd December 2017 …

….seen and assessed by a Psychiatric Street Triage Liaison Nurse … having suicidal thoughts. …

Terence is known to RAID after taking 2 x overdoses in 2016 second December 2017. He has recently moved from the Upminster area.

Terence reports to be a cannabis user and recently stopped using cocaine, which he said he was addicted to.

… On discharge from AMU 17/12/17 Terence agreed to self refer to Drug Services, register at a local GP and refer for Bereavement Counselling of which he has not done to date.

… Attending Officers had found his flat door open. Terence had filled his bath up **[I/S]** *he had reported he had planned* **[I/S]** *to electrocute himself. … was breathalysed at the scene at 0:38..He had his girlfriend,* **[I/S]** *going round to the flat … to self refer for Bereavement Counselling …*
''

17. **21 August 2018**

The medical records state:

"*Essex Partnership University NHS Foundation Trust …*

T/C from Terence brother stating Terence is talking "gibberish",he has taken drugs and now having a psychotic episode. Terence brother stated this is not unusual and he has contacted the police who will be attending when they can. Terence has moved from Leyton to Basildon, Terence reported that he lives miles away and was phoning to see if Street Triage would be attending."

18. **2 September 2018**

The medical records state:

…Role community psychiatric nurse

…Location Basildon police station

"*SEPT …… referred to the Criminal Justice Liaison and Diversion Team for screening at Basildon Police Station as he had markers for ADHD and wants to discuss his mental health issues. He is not currently open to EPUT Mental Health Services. … ..he had a diagnosis of ADHD since the age of seventeen. He has a known history of Cocaine addiction and impulsive overdoses whilst under the influence of drugs. … given input from cruise for bereavement counselling..has been arrested for breach of a non molestation order*
Mr White was offered Screening to ascertain any risk of self-harm, suicidal, physical, mental and social needs, substance misuse or vulnerabilities.

Mr White declined to be screened stating he only wants help to be released from custody so that he can attend Norfolk a two hour drive with his girlfriend so that he can scatter his mother's ashes by 2pm. He refused to discuss any issues and the custody officer was informed verbally. A free text was put into Athena about his decline to CJLDT"

19. **The RCA report states:**

2.09.18: *"Mr W was referred to the Criminal Justice team for screening at Basildon Police Station following his arrest for breach of a non-molestation order. Mr W refused the offer of screening by the Criminal Justice team."*

"On 2nd September 2018 the patient was arrested for a breach of a non-molestation order. He was referred to the CJDLT for assessment. He was seen by a CPN in Basildon police station and declined to be assessed or to discuss any issues."

"CJDLT Criminal Justice Liaison and Diversion Team"

"The referral from Basildon Police Station on 2nd September 2019 to CJLDT resulted in an offer from the CPN to screen Mr W for his risk of self-harm, physical, mental and social needs and substance misuse vulnerabilities. At the time of this referral Mr W was not open to any EPUT Mental Health Services. However he was open to HAABIT which was not reported by the patient and no medical records relating to this were available to the CPN. During discussions with the CPN he reported that he had a diagnosis of ADHD since he was 17 years old. The CPN had acknowledged that Mr W had a known history of cocaine addiction and impulsive overdoses whilst under the influence of drugs. He refused the offer of mental health screening advising that he only wanted help to be released from custody so that he could drive to Norfolk to scatter his mother's ashes that afternoon.

Mr W refused to discuss any issues and the referral was closed with the CPN informing the custody officer of Mr W's refusal to be screened. Due to Mr W's refusal to be screened no further support or advice could be or was offered. The CPN was unaware that he was open to HAABIT at the time and had a follow up psychiatric apt planned in October 2018."

"On 2nd September 2018 Mr W was referred to the CJLDT at Basildon police station as he 'had markers for ADHD and wanted to discuss his mental health. He had been arrested for breach on a non-molestation order. He was seen in the Police station by a CPN.

At the time he was not currently open to EPUT MH services. In the meeting Mr W reported his diagnosis of ADHD age 17 and the CPN noted his history of Cocaine addiction and impulsive overdoses. She also noted that 'he had been grieving for his mother who had died over a year ago and that he had in-put from Cruse for bereavement counselling'.

The CPN offered to screen Mr W for risk of self-harm, physical, mental and social needs, substance misuse vulnerabilities. He declined any screening and just wanted to be released to go to Norfolk to scatter his mother's ashes later that day.
As screening was declined by Mr W and not undertaken his case was closed and there was no detailed reporting of his mental state." (emphasis added)

''HAABIT Havering access and assessment and brief intervention team''.

20. <u>My comments on the above entries for this day:</u>

The RCA report Recommendations section includes *"Teams need to ensure that a full record of all assessment of mental state, risk to self and others and advice is recorded,* ***even when patients decline*** *full assessment and* ***are difficult to engage.****"* (emphasis added)

In my view, based on the above, this recommendation would apply here.

Why was the *"…CPN…unaware that he was open to HABBIT…"* and, had an appointment due with the psychiatrist. Why were the medical records not available to the CPN? How can a clinical decision be made without this information?

21. **<u>30th October 2018</u>**

The RCA report states:

"Mr W was seen by Dr A Consultant Psychiatrist in HAABIT, (his GP at the time was in Upminster). This was ***a follow up apt,*** *as Dr A had seen Mr W previously in August 2018 and undertaken a full assessment which is documented. (****These records were only uploaded to Mobius when GP referred to FRT in March 2019****).*

Dr A recorded Mr W's diagnosis as one of mixed anxiety and depression F41.2 with 'mounting social stressors'. In his August assessment Dr A had also considered an underlying Personality Disorder.

Dr A noted that Mr W had recently undertaken treatment for prophylactic treatment to prevent potential HIV and Hepatitis C infection following sustaining a needle stick injury with an infected needle. Mr W reported to Dr A that the HIV PEP had made him aggressive. He was going through mediation to have access to his [I/S] child *and as part of the requirement for this he had stopped using Cannabis. To help him stay calm he was buying diazepam on the streets, using 20-30mg/day and spending a significant amount of money on this.*

In the interview Dr A stated that Mr W was calm and co-operative, tearful at times and appeared 'moderately depressed'. Mr W denied any 'intention to kill himself' and 'described his daughter as a protective factor', and he was also 'not hopeless' or 'helpless'. Dr A noted no other positive findings on his mental state with no evidence of any psychotic symptoms.

Dr A asked the GP to increase Mr W's antidepressant medication Mirtazapine from 15mg to 45mg nocte and to start him on Diazepam 10mg at night (specifying this should be in the form of 2x 5mg tablets). The plan was to see him again on 7th January 2019." (emphasis added)

22. My comments on the above entries for this day :

I am assuming that "Mobius" is their medical records system. Why were the records only uploaded to Mobius when the GP referral happened in March 2019? These records are critical to understanding my brother; they are my brother's past psychiatric records. In my view, not having these records would significantly undermine the seriousness of his presentations.

23. **16th November 2018**

The RCA report states:

"Fax referral in records from GP to Havering Access, Assessment and Brief Intervention Team, this details MR W was seen in clinic and his Mirtazapine increased and commenced on Diazepam. Plan to be followed up in clinic on 07/01/2019."

2019

24. **11 January 2019**

The medical records state:

"*Essex Partnership University NHS Foundation Trust …*
FRT DUTY
Duty called received from client partner stating that she tried to contact him but no response. She stated that he was meant to attend a rehab centre today but has not been seen. I advised her to contact the police they can dop a welfare check at his address. Although his address on mobius is out of area, partner stated that he lives in the basildon area."

The RCA report states:

"On 11th January 2019 FRT duty had received a call from Mr W's partner as she had tried to contact him and received no response, as he was meant to go to a rehab centre- she was advised to call the police to undertake a welfare check.

"Call to FRT from Mr W partner advising she had been unable to contact Mr W who was due to attend rehab today. Advised to contact police to undertake welfare check at MR W home address."

"FRT First Response Team"

"Mr W's partner contacted FRT duty service on 11th January 2019 advising that she had been trying to contact Mr W with no response and stated he was due to attend a rehab centre. Mr W's partner was advised to contact the police and request a welfare check."

"FRT (Staff): The FRT staff advise that there were 3 calls were to FRT duty, the first of which taken on 11th January 2019 was made by the partner of Mr W raising concern that Mr W was meant to attend a rehab centre but had not been seen, the Community Mental Health Liaison Nurse on duty taking this call advises that at this time Mr W

was not under the Trust's mental health services and they gave advice to contact the police if the caller was concerned about the patient so as they could undertake welfare checks."

"FRT duty received a call from Mr W's partner on 11th January 2019 advising that she had been trying to contact him but had no response. She advised to the CPN who took the call that he was due to attend a rehab centre that day but had not been seen. At the time of the call Mr W was not open to any EPUT Mental Health Services. Mr W's partner advised that he lived in the Basildon area, however the Trust's records held an address that was out of the area. The CPN advised partner to contact the police to undertake a welfare check. In the interview with the Community Mental Health Nurse on 28th June 2019 they advised that they did not recall this telephone call and referred to their notes made on 11th January 2019. They explained that the call received from partner was asking for advice on what to do as she had been unable to contact Mr W, as the patient was not receiving care from EPUT's mental health services and was registered on records as living out of the area it would be routine to advise them to contact the police to undertake a welfare check."

25. **My comments on the above entries for this day:**

- When dealing with the call from my brother's partner, were the Trust aware that my brother was under a Consultant Psychiatrist in HAABIT?

- Did they have access to my brother's psychiatric records?

- Did they even take any steps to see if my brother was under a psychiatric team?

- Why was the solution simply to pass the burden to my brother's partner to contact the police / make an assessment as to whether the police should be called?

26. **15 January 2019 :** The medical records state:

"*Essex Partnership University NHS Foundation Trust … 15/01/2019… Terence was referred by Basildon A&E and was seen in CDU.*

On Speaking with Terence this morning he expressed that he needed support for his drug use, denied having any mental issues stating that he wanted rehab for his drug use.

With regards to his presenting mixed OD, he informed RAID that he took the OD **[I/S]** *. Terence disclosed to RAID that he had some more Diazepam on him which he intends to take to manage his withdrawals; he refused to hand the medication over to RAID.*

Spoke with the Synergy liaison worker based in A&E (**[I/S]** *) and referred Terence to her.*

*17:59- stated that open road wasn't good enough- stating that if no REHAB 'i am going to kill myself, i am not been sectioned, i just need to go into REHAB for a month, if you don't' do it i am going to go and buy more crack you just watch'. He then continued to use a few expletives in expressing his displeasure with the fact that he wasn't been sent to REHAB from A&E. Stated that he wanted to be put in the priory. Stating that he is in a dark place in his life and open road is w***k.*

Terence stated that he was informed that A&E can refer him directly to REHAB for his drugs dependence and was insistent on the admission- my colleague **[I/S]** *also tried to explain to Terence the importance of him engaging with Open Road to help facilitate his request- however he was resistant to this idea stating that services for mental health was poor in the country.*

Terence made his wishes and request clear thus making it impossible to tackle other possible psycho-social issues he may have been expressing.

He continued making threats, stating that he was going to leave the unit and OD on some illicit drugs, becoming loud and aggressively kicked on the door of Resus whilst screaming in expletives.

Terence came back into CDU requesting to use the phone; he later told me he wasn't leaving the unit anymore, stating that he was going to sit in A&E & starve himself until referral to REHAB is granted;

*I offered to get the duty Dr to speak to him, he declined stating 'what they going to do besides ask me to calm down and go to f****** open road'.*

I was dealing with other Issues in A&E when Terence turned up and requested to speak to me privately- I informed him that his behaviour was unacceptable to both staff and patients in the unit; he apologised

and stated that it was due to his frustration. He then informed me that as an alternative to him ending his life, he is now going to use drugs every night and 'i will be calling the ambulance when i get off my head and wasting NHS time till i get REHAB'.

With regards to suicide- Stated that he is suicidal, mental health section is not going to help me nor is open road, all i want is rehab. If no one helps me today I am going to end my life.

Please be aware he made those statements at the beginning of the assessment before everything else that later occurred and has been documented.

PLAN:

- *Unable to make any meaningful plan due to Terence been resistant and declining every support been offered.*
- *Ongoing risk of harm to self through drug use.*
- *Possible risk of accidental self-harm due to life style & drug use.*
- *Possible risk of misadventure."*

"*Basildon and Thurrock University Hospitals NHS Foundation Trust … ? date 8:37. Difficult to read but appears to state :*
… expressed his displeasure @ been asked to self refer to Open Road.
He wanted REHAB or nothing else; making threats to and (?). (illegible)

- *Terence has insight and is able to make decisions for himself.*
- *Terence has capacity surrounding his well-being*
- *Ongoing risk of misadventure.*
- *D/C RAID*

Difficult to read entries but appears to state
15/1/19 09.15
RAID …
He also informed RAID that he is meant to be getting admitted into the Priory in Chelmsford …
…(illegible)…
Spoke with Priory who informed that there was no planned admission in …… (illegible) …
Difficult to read but appears to state :
11:45 ALCOHOL HEALTH TEAM ([I/S] *)*
Terry wants help to help him to stop taking drugs and help him get straight.
I have given him the relevant leaflet to self refer at Open Road."

Letter from *Essex Partnership University NHS Foundation Trust … RAID Psychiatric Liaison Team dated 16.01.2019 states 'assesment dated 16.01.2019 states ''assessment date : 15.01.2019''*

Letter states : Referred by Basildon A&E due to mixed OD [I/S] [I/S] … [I/S] *… Terrence was also said to be using crack cocaine and alcohol; according to referral form handover, he took OD because he didn't have any more cocaine.*

Terence is known to services and has had previous contacts with RAID, Street Triage, and Criminal Justice.

Terence informed RAID that he was due to be getting admitted into the Priory today, however on speaking with the Priory, they informed RAID that Terence had contacted them a few days ago seeking admission following recommendation by GP; they advised that there was no prearranged admission for Terence.

On speaking with Terence this morning he expressed that he needed support for his drug use, denied having any mental issues stating that he wanted rehab for his drug use.

With regards to his presenting mixed OD, he informed RAID that he took the OD [I/S] *Terence disclosed to RAID that he had some more Diazepam on him which he intends to take to manage his withdrawals; he refused to hand the medication over to RAID.*

Spoke with the Synergy liaison worker based in A&E [I/S] *and referred Terence to her.*

*17:59: I saw Terence again he stated that Open Road wasn't good enough- stating that if no REHAB 'I am going to kill myself, I am not being sectioned, I just need to go into REHAB for a month, if you don't do it I am going to go and buy more crack, you just watch'. He then continued to use a few expletives in expressing his displeasure with the fact that he wasn't being sent to REHAB from A&E. Stated that he wanted to be put in the Priory. Stating that he is in a dark place in his life and Open Road is w***k.*

Terence stated that he was informed that A&E can refer him directly to REHAB for his drugs dependence and was insistent on the admission, my colleague [I/S] *also tried to explain to Terence the importance of him engaging with Open Road to help facilitate his request, however he was resistant to this idea stating that services for mental health was poor in the country.*

Terence made his wishes and request clear thus making it impossible to tackle other possible psycho-social issues he may have been expressing.

He continued making threats, stating that he was going to leave the unit and OD on some illicit drugs, becoming loud and aggressively kicked on the door of Resus whilst screaming in expletives.

Terence came back into CDU requesting to use the phone; he later told me he wasn't leaving the unit anymore, stating that he was going to sit in A&E & starve himself until referral to REHAB is granted;

*I offered to get the duty Dr to speak to him, he declined stating 'what they going to do besides ask me to calm down and go to f****** Open Road'.*

I was dealing with another issues in A&E when Terence turned up and requested to speak to me privately, I informed him that his behaviour was unacceptable to both staff and patients in the unit; he apologised and stated that it was due to his frustration. He then informed me that as an alternative to him ending his life, he is now going to use drugs every night and 'I will be calling the ambulance when I get off my head and wasting NHS time till I get REHAB'.

With regards to suicide, stated that he is suicidal, "mental health section is not going to help me nor if Open Road, all I want is rehab. If no one helps me today I am going to end my life".

Please be aware he made those statements at the beginning of the assessment before everything else that later occurred and has been documented.

Management Plan

- *Unable to make any meaningful plan due to Terence been resistant and declining every support been offered.*
- *Ongoing risk of harm to self through drug use.*
- *Possible risk of accidental self-harm due to life style & drug use.*
- *Possible risk of misadventure*."

27. 15/01/2019 - The RCA report states:

"Mr W was referred to the RAID team following ***overdose****. Records state unable to make any plan due to Mr W* ***being resistant and declining*** *support."*

"RAID Rapid Assessment, Intervention and Discharge Team"

"On 15th January 2019 Mr W was seen after he attended Basildon Hospital A&E stating he had taken an overdose of **[I/S]** **[I/S]** *. Mr W had stated to A&E that he took the overdose as he did not have any more cocaine. A&E staff referred Mr W to the RAID team after he had been medically cleared for assessment of his low mood. A&E records regarding the medical history of the patient note previous mental health issues, ADHD, 2 x strokes and a cyst in pineal gland- 'brain tumour'. On speaking to Mr W he informed the RAID team that he needed support for his drug use and access to rehab, he denied having any mental health issues, was resistant and declined offers of support. Mr W informed the RAID team that he had taken the overdose* **[I/S]** *and that he had some more Diazepam on his person which he intended to take to manage his withdrawals; he refused to hand over the medication to the RAID teams Psychiatric Liaison Nurse. Mr W also stated that he had been informed that A&E could refer him directly to rehab for his drugs dependence, it was explained that neither the RAID team nor A&E were able to facilitate this and that he needed to engage with the Open Road services to help facilitate rehab.*

The Psychiatric Liaison Nurse spoke with the Synergy liaison worker, a therapy and addiction service based at Basildon Hospital A&E and referred Mr W to them to assist. Synergy spoke to Mr W who stated that he wanted to obtain help to stop taking drugs. He was provided with information by Synergy to self- refer to Open Road. Mr W became verbally abusive and the team were unable to make any meaningful plan due to his resistance and declining offers of support available and he was discharged back into the care of his GP."

"RAID (Staff): Mr W was assessed by the Psychiatric Liaison Nurse on 15th January 2019 at Basildon A & E after according to records attending A & E himself. Mr W informed the Psychiatric Liaison Nurse that he was due to be admitted to the Priory today for rehab. However on the nurse contacting the Priory they informed that whilst Mr W had contacted them a few days previously following a recommendation by his GP there was no planned admission for him. The nurse explained that he would need to engage with Open Road to help facilitate this, however Mr W was resistant to this, as mental health services were unable to directly refer to the Priory, and he was frustrated by this. Due to Mr W's increasing frustration with the Psychiatric Liaison Nurse, his senior also tried to explain to Mr W the importance of engagement with Open Road to gain access to rehab services.
The Psychiatric Liaison nurse advised that Mr W presented with insight into needing help with his drug dependency and that he did not have any concerns regarding mental health issues through his presentation. He was not acutely mentally unwell or displaying any

psychotic symptoms and he was able to articulate that he wanted help with gaining access to rehab, and not for his mental health. As Mr W had declined further assessment he was referred back to his GP and discharged from services."

"On 15th January 2019 the Mr W presented himself at Basildon Hospital A&E advising that he had taken an overdose of **[I/S]** **[I/S]** *In the A&E notes within Trust records, Basildon Hospital had recorded that Mr W admits he is a cocaine addict and had taken Diazepam because he had no cocaine to take. It is noted that he had 'thrown up' and had no seizures, his bloods were NAD (No abnormality discovered), and he was* ***unsteady on his feet*** *and had* ***dilated pupils.*** *The plan was to administer intravenous fluids and refer to mental health after. The patient's previous medical history had been noted on this record as mental health, "ADHD, 2 x strokes, cyst on pineal gland 'brain tumour' ".*

Following medical treatment being administered by Basildon Hospital Mr W was medically cleared and referred to the RAID team for low mood.

In interview with the Psychiatric Liaison Nurse on 2nd July 2019 he explained that Mr W had denied he had mental health issues and that he just wanted rehab for his drug use. The nurse advised that Mr W stated he had been advised that if he attended A&E they would be able to refer him directly to rehab services, the nurse did not know who had advised Mr W and investigators were unable to determine where this advice had been obtained. Mr W advised the Psychiatric Liaison Nurse that he was meant to have been admitted to the Priory that day, however the nurse confirmed that they had contacted the Priory and they had informed him that there was no planned admission although Mr W had called them directly a few days ago seeking admission as recommended by his GP. The nurse explained that he would need to engage with Open Road to help facilitate this, however Mr W was resistant, as mental health services were unable to directly refer to the Priory, and he was frustrated by this. Due to Mr W's increasing frustration with the Psychiatric Liaison Nurse, his senior also tried to explain to Mr W the importance of engagement with Open Road to gain access to rehab services.

The Psychiatric Liaison nurse advised that Mr W presented with insight into needing help with his drug dependency and that he did not want any assessment for mental health; ***the nurse states that they did not have any concerns regarding mental health issues through his presentation or his capacity****. Mr W presented as not acutely mentally unwell or displaying any psychotic symptoms and he was able to articulate that he wanted help with gaining access to rehab, and not for his mental health.*

The nurse referred Mr W to a colleague within the Synergy services based in Basildon Hospital A&E (Drug and Alcohol service). The A&E referral records held show an entry from Synergy that states Mr W wants help to stop taking drugs and help him get straight. He was provided with information to self-refer to Open Road.

Mr W was ***discharged from RAID services*** *as they were* ***unable to engage him in mental health assessment*** *and had tried to signpost him to services that could help with rehab, a report was sent to his GP.*

Investigators advised the Psychiatric Liaison Nurse that the family had indicated concern regarding a brain tumour and if he been aware of this medical history at the time of referral. The nurse advised that Mr W had been triaged in A&E for his physical health issues, and medically cleared before referral to RAID, no issues were highlighted at the time to the nurse. The records provided at referral from A&E note in the past medical history, cyst in pineal gland (a benign finding and reported in 1-4% of people who have had MRIs) reported by the patient as a 'brain tumour'. Clinical evidence suggests that if it had of been a major concern the neurologist would have would have taken further action and there is no evidence of this in the records investigators obtained.

On the investigators review of the notes from Basildon A&E there is clear mention of past medical history including, ADHD, stroke, cyst on pineal gland 'brain tumour' (the quotation marks denoting that this was Mr W's words)."

On 15th January 2019 he attended A & E following an overdose of **[I/S]** **[I/S]** *He had self-presented at A & E (walked in). Although unsteady on his feet, he said that he vomited after taking the diazepam, which he had taken following running out of cocaine.*

All his physical tests had come back within normal ranges. He was ***re-hydrated with IV fluids*** *and then medically cleared to be seen by the RAID team. The A & E doctor noted that Mr W admitted he was a 'cocaine addict' and in his past medical history "ADHD, 2x Strokes, Cyst on the pineal gland, 'brain tumour'. - indicating by quotation marks that this was a quote from Mr W.*

In Mr W's contact with the RAID team he 'denied he had mental health issues' and that he wanted Rehab for his drug use. A difficult interaction took place where Mr W was frustrated and hostile that his request for direct referral to Rehab was not taking place and instead he was being directed to 'Open road' services to facilitate this. ***He threatened to end his life*** *and* ***then use drugs repeatedly*** *to be able to use emergency services until he got rehab. He had* ***refused to***

hand over further diazepam *that he had in his possession that he was using to help with running out of cocaine.*

The liaison nurse documented that it was difficult to form a meaningful plan with Mr W. He was noted to have mental capacity. Raid wrote to the GP on 16/1/19 and in this correspondence noted that Mr W had said that he was due to be admitted to the Priory for rehab after recommendation by the GP. Raid contacted the Priory and found that although Mr W had contacted the Priory himself, no arrangements were in place to admit Mr W.

Although Mr W was noted to have capacity in his contact in A & E and his threats to commit suicide seemed in response to not being referred to Rehab ***there is no clear documented assessment of his mental state or a comprehensive documented assessment of risk to self*** *and others.*

However it is clear that his presentation was different to seeing Dr A the previous October. (These ***notes were not available to A & E****).” (emphasis added)*

“15 Mar 2019 …
From …Ballards Walk Surgery…
To To Whom it May Concern
…
I can confirm that Mr White suffers from anxiety, depression and personality disorder. He is also having to help look after his father who lives in Colchester and his own children who live in….I feel loosing his driving licence would have a significant impact on his mental health and prevent easy access to his family”

28. <u>My comments on the above entries for 15.01.2019 :</u>

In my view the failings in my brother’s care are numerous on this day. They include the following:

With regards to why he was not detained / sectioned, The RCA report states:

“There were ***no clear indications to detain*** *Mr W under the Mental Health act when he presented in A&E on 15th January 2019. He was not displaying psychotic symptoms or recorded as being overtly depressed. He was angry and frustrated but able to apologise to staff*

for his behaviour and his main difficulties were his battle with his substance misuse problems and he had sought help for his overdose voluntarily. He was deemed to have mental capacity and to be aware of his decisions that he was making.

Welfare checks were carried out the next day and the police found no reason to detain him using emergency powers available to them under the mental health act."

The RCA report states with regards to the question ***"Suicide survey tool, why was this not used?"***:

"This would be used by A+E staff but is not used by the RAID team, there is ***no record of its completion in the referral records handed over from Basildon & Thurrock Hospital A & E*** *staff. The Trust do have a* ***comprehensive risk assessment*** *tool which can be used during an assessment but was* ***not able to be undertaken*** *on 15th January 2019 due to* ***Mr W's presentation****."*

In addition, it states above that at this presentation "***there is no clear documented assessment of his mental state or a comprehensive documented assessment of risk to self*** *…"*

The obvious question is, if this assessment of his mental state and risk is not done, then how can one make a decision as to whether my brother needed to be sectioned?

My brother stated he had taken an overdose, was administered intravenous fluids was unsteady on his feet, had dilated pupils, refused to hand over medication, threatened to end his life and "…*then use drugs repeatedly*…", yet "…he denied having mental health issues." I find it unbelievable that the solution to this presentation was to discharge him to his GP. How is it possible to treat someone so vulnerable in this way?

Finally, it also states above *"However it is clear that his presentation was different to seeing Dr A the previous October. (These notes were*

not available to A & E).” Again, why was there no access to these records? To me, the “*presentation was different*” is critical information that the staff should have had access to.

29. **16/01/2019**

The medical records state :

‘Essex partnership university NHS foundation Trust …FRT DUTY

T/C received from client partner who expressed concerns about his mental heath. She said he was seen and assessed by RAID on the 15.01.2019 and discharged. He was offered help but declined, according to partner police was called this morning to do a welfare check on him and she was told that he’s fine. The partner continue to express her concerns about his suicidal thoughts and potential overdose. I reassured her and explained that he has been assessed by the mental health service and police who both have the right to detain him if necessary. They have not done that. I explain that the risk will be assessed as he presents’.

30. The RCA report states:

“Call received by FRT from clients partner expressing concerns about MR W mental health and ***suicidal thoughts****.”*

“Mr W’s partner contacted the FRT duty service again on 16 January and expressed concerns about the patient’s ***mental health****. It was explained that the patient had been* ***seen by RAID the day before*** *and had declined any help. The partner advised that the* ***police had undertook a welfare check that morning*** *and reported that he was fine. There was no indication that there was any further urgent risk.”*

“The CPN was again on FRT Duty on 16th January 2019 when the partner called again to express concerns about Mr W’s mental health and her concerns about his suicidal thoughts and ***potential overdose****.*

*The **CPN gave reassurance** to the caller that Mr W had been **assessed by the RAID team and the police** who had undertaken a welfare check earlier that day and that they **had the option to detain him** if they felt necessary under the Mental Health Act. The CPN advised that she would not have seen this as an urgent risk, as Mr W had been **seen by RAID the day previous and declined any help** and further assessed by **police undertaking a welfare check** that morning. The CPN advised that she would have advised the caller to take the patient to A&E for the Mental Health Liaison team to review if further concerns arose."*

*"The telephone call to FRT duty on 16th January 2019 from Mr W's partner was received by **the same** CPN as the call to FRT Duty on 11th January 2019. Mr W's partner was expressing her concerns about his mental health state. Mr W's partner advised the CPN that he had been seen by the RAID team at Basildon Hospital A&E department and discharged having been offered help but declined. The partner further advised the CPN that she had raised her concerns with the police who had undertaken a welfare check that morning and reported back to her that he was fine. The partner continued to express her concerns about Mr W's **suicidal thoughts and potential risk of overdose.** The CPN provided her reassurance that he had been assessed by the RAID team the day previous and the police who could both detain him if they felt necessary. In the interview with the CPN she advised that she had assessed this was not an urgent risk on the basis that he been seen by the RAID team the day previous and a police welfare check had been undertaken that day. There had been **nothing within the records from the RAID assessment that demonstrated any urgent risk to her** and the RAID teams' offer of support and assessment had been declined by Mr W. The CPN stated that she would have advised caller to take Mr W to A&E for the MH Liaison service to assess if further concerns arose although this advice was not documented in records."*

"His partner contacted services the same day 16th January 2019 as RAID wrote to GP as she remained concerned about his welfare and the call was taken by FRT duty. His partner informed FRT that police

had undertaken a welfare check that morning and 'he was fine'. However she remained concerned about him." (Emphasis added)

31. My comments on the above entries for this day:

There was a new call voicing concerns regarding suicidal thoughts and potential overdose. How can the current risk be assessed without speaking to my brother?

05.03.2019 *: The RCA Report states : ''..05/03/2019 Fax referral in records from Havering Access, Assessment and Brief Intervention Team to GP advising patient has reported difficulty in obtaining medication and would like a referral to local mental health services."*

32. Computerised GP records state :

7th March 2019 *''Accident and emergency letter to Ballards Walk Surgery''..*

"07 Mar 2019 Accident and Emergency Letter to Ballards Walk Surgery
…Letter From BTUH …"

Letter dated 7 March 2019 from Basildon University Hospital to "Dr Surgery Ballards Walk" states:

"…Please see below for details of the recent attendance at the Emergency Department at Basildon and Thurrock University Hospital …
Arrival Date:07 March 2019
Arrival Method: Emergency Road Ambulance
Presenting Problem: Overdose Poisoning
Accompanied By: Police
Referral Source: Emergency Department
…
Treating Clinician: Dr [I/S]
Diagnosis: No abnormality detected (Suspected diagnosis)
Treatment: Guidance / advice only Guidance/ advice – verbal
Investigations: …Blood Tests…
…Discharge Date: 07 March 2019
Clinical Advice:

Presented with hand and feet swelling today for a few hours. Concerned because he took cocaine 2 days ago. No sob, no chest pain, no headache, no abdominal pain, no PR bleeding

O/E
…alert, GCS 15, neurological examination normal
…mobilising normally, normal hand movement

Bloods unremarkable

Discharge Follow Up: General Practitioner
…
Safeguarding: No safeguarding issues identified"

33. My comments on the above:

Why was this attendance not part of the RCA report. Was a psychiatric assessment done given that it states above that he came by ambulance and that the presenting problem was "overdoes poisoning"? I would like the Inquiry to obtain Terry's full set of medical records from this Trust given the proximity in time of this attendance to the day that Terry died.

34. **13 March 2019**

"…Had relapse using cocaine recently Struggling with chronic pain Rash on back, will see
Medication review done…
Referral to psychiatrist…"
"…Due in court for speeding 12 points on licence father ill in Colchester Daughters in … Needs his car…
…Diazepam …tablets…"

35. **15 March 2019**

<u>The medical records include:</u>

Letter from "*Ballards Walk Surgery '… stating 'Referral''*

Letter is to 'First Response Team … Thurrock Community Hospital''

Letter dated 15 Mar 2019 …

Letter states :

I would be grateful if you could continue the follow up on this 36 year old man who has previously been under the care of the mental health

services in Havering. He has recently moved to Basildon and has been recommended by the Havering Mental Health Services that he be referred on for further supervision. He has had a history of anxiety and depression and has taken serious overdoses in the past. He has also had a history of drug abuse in the past, but apart from a recent brief relapse with cocaine he has been drug free for some time. He has also been thought to have a degree of personality disorder. I have enclosed some correspondence from Havering Mental Health services for your information. He is no longer taking Mirtazapine, but is still taking 15mg Diazepam daily and some Pregabalin. I would be grateful if you could continue his follow up care."

The subsequent medical records include : Fax message from NELFT NHS foundation Trust (NELFT), havering access, Assessment A Brief intervention to Dr [I/S] surgery dated 5th March 2019 stating Mr white has been in contact reporting that he is having difficulty obtaining medication. Please find attached copies of recent care plans and a change of medication fax should his recent not be in your care. He is requesting referral to local MH services which we have advised him to speak to you about..'

Letter from NELT to valderian medic centre, entitled care plan. Date of Clinic Appointment. Letter notes current medication and changes to the care plan. The subsequent page includes matters such as the follow up plan and 'summary of interview'. The impression was ''mixed anxiety and depression, mounting social pressures'.

There is a document where the initial page appear to be missing. It states the main contact as Dr [I/S] HABBIT. The summary of interview section states '…terry has a history of self-harming behaviour and has taken serious overdoses in the past. He took two overdoses in the past , one in October last year and the second was in early December last year. He had to be admitted in ITU following second OD when he ingested [I/S] with an intention of killing himself…on the subsequent page the 'plan states'..he will be reviewed in the clinic on 2nd October 2018

Letter from NELT dated 16.11.18 to Hedierdan medical centre stating ..'if you would implement the changes as below..'

36. **18/03/2019**

The RCA report states:

"Referral letter received from GP to FRT asking for FRT to follow up Mr W's care having recently moved to Basildon dated 15/03/2019."

"On 18th March 2019 a faxed referral from Mr W's GP was received by the FRT service confirming his current medication and asking EPUT to continue his follow up care. Recent correspondence the GP had received from HAABIT was included with the referral."

"HAABIT Havering Access and Assessment and Brief Intervention team"

"The next contact was via GP referral dated 15th March 2019 received by fax 18th March 2019. This was from a Basildon GP so it seems Mr W had been able to re-register. The GP included the ***background records from HAABIT*** *and indicated his history of 'anxiety and depression and* ***serious overdoses'****. He noted Mr W's use of cocaine but that he had been 'drug free for some time'. The GP noted that he was thought to have a 'degree of personality disorder'. He had stopped his antidepressant medication, Mirtazapine, but was still taking prescribed Diazepam and 'some Pregabalin'. It is not clear from the GP letter whether the Pregabalin was prescribed or not - as it also can have a street value. There was no indication of acute risk to self in the GP referral." (emphasis added)*

37. My comments on the above entries for this day:

- I would like the Inquiry to please obtain a full set of my brother's GP records to ascertain the communication between

the GP and the Trust as it is clear that this relationship is key in ensuring safe care.

- Was the GP aware of my brother's mental health presentations which took place within the last approximately 2 months?

38. **21 March 2019**

The medical records state:

"FRT/CAS MOBIUS EPISODE PATHWAY…
FRT Basildon… SCREENING DATE: 21.3.2019 SCREENED BY: Dr [I/S]
Offer Routine FRT/CAS Assessment Appointment (Appointment within 14 days)…

- *Assessor ONLY…"*

The RCA report states:

"FRT Screening completed, outcome was to offer routine assessment appointment within 14 days."

"The referral was screened by a Consultant Psychiatrist on 21st March 2019 and a routine assessment appointment was asked to be scheduled."

"The referral was screened by the [I/S] *Consultant Psychiatrist on 21st March 2019, and deemed for routine assessment by a nurse and an apt* ***within 14 days****." (emphasis added)*

39. My comments on the above entries for this day:

I would like the Inquiry to find out whether, when screening the GP referral letter, was the Consultant Psychiatrist aware of brother's presentations in A&E and the concerns raised about him earlier that year? Did this psychiatrist appreciate my brother's presentations?

40. **22 March 2019**

The medical records state:

Letter dated..“22nd March 2019 …from ‘’RBAC Head Office..``to Mr Terence White’… stating..

‘’..Following receipt of a referral for our services, we would like to invite you for an Initial Assessment with our First Response Team. …
***Please telephone or ask a representative to telephone 01268 739122 in order to arrange an appointment**. …*
Should we not hear from you within 4 working days we will assume you no longer want our help and we will let the referrer know that we are closing your file. …” (emphasis added)

Email correspondence states:

From .. **[I/S]** *(ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST)*
Sent : 22 March 2019 09:58 …
Stating : ‘’ Please offer appointment with a Nurse…”

From ‘’FRT Basildon..“*(ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST) ‘’*
Sent .” 22 March 2019 14:26’’
To .. ‘’Basildon appointments (ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST) …’’
Stating ..’’ Please find attached completed Screening Outcome Form. …”

The RCA report states:

“*Letter sent to Mr W from FRT asking **him to contact the team** to arrange an appointment.” (emphasis added)*

"A letter was sent to Mr W on 22nd March 2019 asking him to contact the booking line and arrange a suitable appointment."

"Mr W was written to with an opt in letter on 22nd March 2019 giving him 4 days to respond to be offered an apt."

My comments on the above entries for this day:

I would like the Inquiry to find out what "an opt in letter is" and whether it was an appropriate method to arrange an appointment with someone like my brother with all of his mental health / life style struggles.

41. The below entries appear to be part of GP records :

"24 Mar 2019 Walk in Centre to North Colchester Health Centre
Letter type Walk in Centre
Letter to North Colchester Health Centre
Letter from Mr Terry White"

The document appears to state:
"North East Essex…
Bitten by pitbull on left hand
Lot of pain"

42. My comments:

- I would like the Inquiry to obtain Terry's full set of medical records from this Trust / Health centre given the proximity in time of this attendance to the day that Terry died.

- This document appears to have Terry's mobile phone number on it – is this the same number that EPUT and GP had on their systems? I am checking this due to the incident later in the timeline of events on 10 April 2019 (see below), when the clinical staff were unable to contact Terry.

43. **28 March 2019**

The medical records state:

Letter dated 28/03/2019 from 'Administration services. Thurrock community hospital'

To : Terrance White stating '' This is to confirm an Assessment appointment has been booked for you as follows:
DATE: 17/04/2019 …
VENUE: The First Response Team, Community Resource Centre, Basildon Mental Health Unit, Basildon Hospital…"

Yours sincerely

First response team

The RCA report states:

*"Confirmed appointment letter sent to Mr W from FRT for **17/04/2019**." (emphasis added)*

"On 28th March a letter was sent to Mr W confirming that an appointment had been scheduled for 17th April 2019."

*"He was written to on 28th March 2019 to offer him an apt on **17th April 2019**." (Emphasis added)*

44. My comments on the above entries for this day:

The RCA report states '*The referral was screened by the* **[I/S]** *consultant Psychiatrist on 21st March 2019 and deemed for routine assessment by a nurse and an apt within 14 days.'* So why was an appointment offered for the 17 April?

Did my brother reply to the initial "opt in" letter? If not, I would like the Inquiry to find out why the Trust would send him a further appointment letter without checking if he received the first one.

If my brother did not receive/ reply to the initial opt in letter then was there any investigation as to why this was the case?

45. With regards to actioning the referral letter from the GP, the RCA report states:

> *"The referral from Mr W's GP dated 15th March 2019 and faxed to the Trust on 18th March 2019 was handled appropriately* ***based on the information provided within*** *which indicated this was a routine referral to continue follow up care from HAABIT, there was nothing that indicated that this was urgent referral or that Mr W had any current suicidal ideations. The GP's referral was screened by a Consultant within 3 days (21st March 2019) who determined based on the information provided a routine appointment should be offered and a booking letter was sent to Mr W to call the appointment line to schedule this. On 28th March 2019 Mr W was sent a letter confirming that he had a scheduled appointment for 17th April 2019.*
>
> *The referral received by the team was processed and assessed quickly, the appointment scheduled was within the 4 week wait period for* ***non-urgent referrals*** *and the booking appointment letter gave details of how help or support could be obtained from FRT in the interim, providing their contact details, out of hours services and advice on visiting A&E if urgent assistance was required.*
>
> *Investigators did not identify any concerns in the assessment and scheduling of the appointment." (emphasis added)*

46. <u>My comments on the above entries</u>

It appears from the above that the referral letter was screened:

- "*…based on the information provided within which indicated this was a routine referral to continue follow up care from HAABIT…"*

- When screening, was the overdose approximately 2 months earlier and the multiple entries regarding suicidal thoughts taken into consideration?

Computerised GP records state: 1 April 2019 *"Did not attend for healthcare assistant appointment…."*

47. **10 April 2019**

The medical records state:

"… 10/04/2019 …
Duty call from **[I/S]** *from DWP, she called to highlight that Mr White, had completed a questionnaire for the DWP on 13.2.19 and he ticked that he was suicidal. They have only just reviewed the information and called to inform mental health team.*

Action:
Duty to make contact with Mr White, but unfortunately no contact details on the system.
Duty to call GP surgery to establish any contact detail. GP happy to give details they have on record. Duty staff then tried to call Mr White on the contact details from GP but the number was not available. Duty unable to establish contact with Mr White.

Mr White is pending assessment with FRT on 17th April 2019…."

The RCA report states:

"Call received by FRT from the Department of Work & Pensions, they highlighted that they had received a completed questionnaire on 13/02/2019 where Mr W had ticked that he was suicidal, the form had only just been reviewed. FRT attempted to make contact with Mr W but could ***not locate contact details on records****. GP contacted and provided details they had on record but the* ***telephone numbers were unobtainable****. FRT were* ***unable to establish*** *contact with Mr W." (emphasis added)*

"A telephone call was received by the FRT duty Senior Social Work Practitioner from the Department for Work and Pensions on 10th April 2019 advising that they were in receipt of a questionnaire from Mr W

completed on 13th February 2019 in which he had ticked that he was suicidal. They had only just reviewed this information and were calling to notify mental health services. The Senior Social Work Practitioner attempted to contact Mr W however the ***telephone number on the system was unavailable****. The Senior Social Work Practitioner telephoned the GP to see if they held any other contact details, they provided the same number FRT already held and stated it was the only number they held for the patient." (emphasis added)*

"On 10th April 2019 the Senior Social Work Practitioner took a duty call from the Department of Work & Pensions. They advised they had received a completed questionnaire on 13th February 2019 where Mr W had ticked that he was suicidal, the form had only just been reviewed. The Senior Social Work Practitioner attempted to make contact with Mr W but could not locate contact details on records. She contacted his GP and confirmed the contact details they had on record was the same as the number the Trust held which was unobtainable. The Senior Social Work Practitioner advised investigators that she has ***not assessed this contact as an urgent risk due to referral from the GP in March 2019 which did not indicate an suicidal ideations." (emphasis added)***

"The call received to FRT duty from the DWP on 10th April 2019 was to advise that on a form that had been completed by Mr W he had ticked he was suicidal, the form had been completed on 13th February 2019 but only just reviewed by the DWP. In interview with the Senior Social Work Practitioner who took the call she advises that she cannot recall this telephone conversation and referred to her notes for the purposes of the interview. Her notes identified that she attempted to contact the telephone number held for Mr W in Trust records but there was no response. She called the GP to verify the contact details that provided the same telephone number and stated it was the only number they held for Mr W.

The Senior Social Work Practitioner advised investigators that her assessment of the risk was that this was ***not an urgent*** *situation. She would have* ***considered and taken into account*** *recent contact with*

EPUT services which had taken place after the completion of the form for DWP in February 2019, of which the last face to face contact with Mr W ***was 15th January 2019 when the patient was referred to RAID from Basildon Hospital A&E where no urgent risk was identified.*** *She would have also considered the* ***recent referral to FRT from the GP received on 18th March 2019 which had not identified any urgent risk*** *and subsequent screening had determined a routine appointment should be made; this appointment was also due to take place in a week's time. Due to these considerations of risk she did not feel any other action was required.*

Investigators asked if she had considered ***asking the police*** *to undertake a welfare check, she advised that she had not considered this at the time; however* ***her assessment of the risk was low.***

Investigators noted entries in the ***GP shared care records on 5th April 2019 that they had also been contacted by the DWP,*** *the notes are unclear of the reason for the call, however the notes state 'it became clear that they needed to speak to mental health services' and they provided contact details. This contact with the GP would not have been known by the Senior Social Work Practitioner. In light of this Investigators reasoned that it may have been* ***beneficial for her to have alerted the GP*** *so as this concern could have been discussed with Mr W contacted or attended his GP surgery." (emphasis added)*

"On 10th April 2019 a call was received by FRT from the DWP. They highlighted that they had received a completed questionnaire on 13th February 2019 where Mr W had ticked that he was suicidal, the form had only just been reviewed.

FRT duty worker attempted to make contact with Mr W but could not locate contact details on records. His GP was contacted and provided details they had on record but the telephone numbers were unobtainable. Therefore FRT were unable to establish contact with Mr W."

48. My comments on the above entries for this day:

The Trust could not make contact with my brother. However, did they try to contact next of kin/ any other family members?

From my understanding, reasons that the Trust did not consider this to be an urgent situation is based on the following :

- *"…the last face to face contact with Mr W* ***was 15th January 2019 when the patient was referred to RAID from Basildon Hospital A&E where no urgent risk was identified."***

  As I have already stated above, how can it be concluded that there was no urgent risk when it does not appear that a risk assessment was completed during this RAID assessment.

- "…***referral from the GP in March 2019 which did not indicate an suicidal ideations."*** In my view the letter from the GP does not reflect the January 2019 presentations (which EPUT themselves would have a record of in any event.)

49. Once again, another lost opportunity. I would also request that clarification is obtained with regards to

    (i) '' the entries in the GP shared care records on the 5th of April 2019 that they had also been contacted by the DWP.
    (ii) Why a form completed on 13th February 2019 which ''…had ticked that he was suicidal..' was renewed by DWP so much later in time.

50. **14/04/2019**

The RCA report states : "Mr W was found deceased by hanging at his home address."

51. **15/04/2019**

The RCA report states : "Essex Partnership University NHS Foundation Trust received notification from the Coroner's Office of the incident."

"The Trust were notified by the Coroner's Office on 15th April that Mr W had been found hanging by at his home address on 14th April 2019 prior to his scheduled FRT assessment appointment on 17th April 2019. Mr W had been found by the police in a bathroom cupboard suspended by the neck **[I/S]** *"*

52. **Autopsy reports and toxicology reports**

The RCA report states : "Autopsy reports and toxicology reports inform that Mr W was intoxicated by alcohol, cannabis and cocaine at the time of his death. The Toxicology report states that the concentration of cocaine would have been affecting his state of mind. There were also low levels of benzodiazepines, diazepam, nordiazepam, and temazepam in his blood"

Toxicology report dated 28 May 2019 states *"The deceased was found by the police dead in a bathroom cupboard, suspended by the neck* **[I/S]** **[I/S]**

INQUEST

53. I would like the Inquiry to obtain and consider a transcript / recording of the Inquest. I am concerned that the Inquest was not sufficiently thorough at all. The whole inquest hearing only lasted for around 20 – 30 minutes. The whole process felt very rushed, and we were not supported whilst we were grieving the loss of my brother. I understand that the Inquest witness list in my possession does not contain any of the Trusts' clinical staff involved in treating Terry. It appears that the witness list only contains EPUT's investigation team for their own RCA report, namely **[I/S]** and Dr

[I/S] I would like the Inquiry to hear from the staff involved in my brother's care in 2019.

54. The Inquest bundle includes the following entries in the following statements :

55. I understand that [I/S] witness statement (who was Terrys partner's) which states:

> *"On Friday 12th April, I received a phone call from Terry, about 7pm, he was very drunk and was very upset and crying. This was mainly due to that he said he had a cyst on his brain that he told me about …4 months ago. Terry said he had an appointment at a hospital in regards to his brain booked for Monday 15th April."*
>
> *"I cant think of anything that would …(illegible)… caused Terry to commit suicide except his mental health and his cyst…(illegible)…brain"*

56. I understand that [I/S] witness statement (friend), which although very difficult to read, appears to state:

"I had also been seeing him sporadically for a few weeks, trying to look after him pending an operation for a brain tumour which he had, & for this he was on a lot of medication"

57. Given the fact that Terry appeared to be so upset about the appointment for the "cyst on his brain" which is stated above to be on 15 April (and he died on the 14 April), I would like the Inquiry to obtain more information on his brain condition, so that we have a better understanding of this physical condition and any impact it may have had on his mental health.

58. **The 'Care and Service delivery Problems' section in the RCA report states:**

*"Mobius records were available that documented previous presentations in to **A & E** in December **2017** when a **comprehensive risk assessment** was documented as well as **collateral history from contact with his half-sister**, along with previous assessment from October 2016 again following A & E*

*attendance with overdose at Basildon Hospital. These **add depth and breadth** to understanding Mr W and his **difficulties.**" (emphasis added)*

59. This confirms my concerns with regards to what was not done during the 2019 presentations.

60. **In the RCA report, it states under 'Associated Factors':**

"PATIENT FACTORS

1. *Developmental factors: early physical trauma, breakdown in family relationships* **[I/S]**
2. ***Social factors**: debt, and loss of access to elder daughter.*
3. ***Physical** health problems: history of stroke at a young age secondary to cocaine use (reported by family).*
4. ***Substance misuse**; cocaine, alcohol, benzodiazepines, and anabolic steroids.*
5. ***Anxiety and depression.***
6. *Features of Personality disorder*
7. *Historic diagnosis of **ADHD**"*

(**emphasis added**)

61. In my opinion, the 'patient' factor which appears to have been prioritised and focused on was that of substance misuse. Why? This is further highlighted by the following entry from the RCA report which states that the 'system factors' include:

> *"Lack of individual key working for people whose **main presenting problems** is **substance misuse** within statutory NHS services rather than with third sector organisations (in this case Open road)." (emphasis added)*

62. This is disappointing. In my view the '*main presenting problems'* include his mental health. In my view the focus was disproportionately on his drug addiction.

63. In response to the families' concerns as to whether ADHD medication was prescribed, the RCA report states:

> *"From the information available to investigators no ADHD medication was being prescribed. In the most recent Outpatient contact with HAABIT records which accompanied the GP referral to the Trusts FRT services on 18th March 2019 there was* ***no mention documented of ADHD*** *to the consultant by Mr W when he saw the consultant. He was being treated by the consultant with antidepressants, (Mirtazapine) and Diazepam for anxiety." (emphasis added)*

64. I have stated multiple entries above which show the concern which my brother had with regards to his ADHD.

65. In response to the families' query as to "What happens when individuals do not engage?", the RCA report states:

> *"They remain under the care of their GP in the community and can re-access services through their GP as Mr W did, unless they present to emergency services."*

66. How is this approach an adequate risk assessment of the individual? What if they did not engage because they could not engage due to their "patient factors" like these listed above?

67. If more of the above listed 7 patient factors were taken into account during each interaction with the Trust, then in my view my brother would not have taken his life.

68. **In the RCA report, it states under '*System Factors*'**

> *"**Lack** of **integrated medical records** across **primary** and **secondary care** and **between organisations** that also contain **historical records** detailing contact with services in the pre-digital era."*

69. I have already raised my concerns as to whether staff (making critical decisions regarding my brother) had access to / reviewed medical records.

70. **In addition to that mentioned above, Recommendations / Care and service delivery problems in the RCA report also includes the following**

"Teams need to ensure that a full record of all assessment of mental state, ***risk to self*** *and others and advice is recorded,* ***even when patients decline*** *full assessment and are* ***difficult to engage."***

"Attention to detail in record keeping and regular cross referencing of dates of birth to ensure correctly recorded."

"Whilst the merger of the two Trusts is still in its early stages care should be taken to ***ensure all patient records systems are checked****, using all variations of patient detail, i.e. name, DOB, NHS Number, to ensure records are complete and* ***no risk is posed*** *to their care and treatment."*

"He was treated for ***his overdose in January 2019****. However it is also clear due to his level of frustration and aggression in A & E and difficulty engaging him a more* ***comprehensive*** *plan to address his mental health needs was not able to be put in place at this time. (emphasis added)*

In my opinion, the first step in creating a 'comprehensive plan' should have been assessment of risk.

71. The RCA report goes on to state :
"The GP was written to promptly and informed of the situation. The GP could then have contacted services if Mr W had presented again and was in a frame of mind to engage with MH services. As was the case 2 months later when the GP referred to FRT."

As stated above, I would like the Inquiry to please obtain a full set of my brother's GP records to ascertain the communication between the GP and the Trust as it is clear that this relationship is key in ensuring safe care.

72. **Under 'ROOT CAUSES' the RCA report states**

"Mr W was a suicide risk and there was an ***escalation*** *in his contact with services in the* ***two years preceding his death****, following the death of his mother 2016, in the context of his developmental history.*

"However the timing of his eventual suicide could not have been predicted or prevented. The report ***does not capture the instability present in his life or the extent of social situation****, as this was* ***not recently assessed*** *or thoroughly known. Even the extent of his substance misuse difficulties, remained* ***unclear****; alongside his* ***anxiety and depression*** *and historic diagnosis of* ***ADHD.***

There is **no root cause** *that could have prevented Mr W's death.*

His moves between services in Havering, and EPUT and change of GPs, and lack of Mr W's engagement with Open road, lead to transitions in his care where no one knew him well and could gauge that he was potentially more at risk than he was conveying in his contact with services over the last six months. He could indicate this on a form for the DWP but not on a more personal individual level, which represented his difficulty trusting and engaging in face to face contact. His partner seemed to be aware of his risk to himself and alerted services as needed and services responded appropriately on the information that was to hand. This was in the absence of any one person knowing Mr W intimately enough to engage him and provide one to one support, which is the only thing that may have potentially helped him. This would have been by developing a comprehensive understanding of his difficulties and facilitating support and engagement with appropriate services to address his difficulties and needs. His longstanding struggle with substance misuse combined with mental health problems, diagnosed as anxiety and depression, alongside potential ADHD in adulthood and personality difficulties, combined with anxieties about his physical health, debts, and breakdown in family relationships were significant factors contributing to him taking his own life by hanging while intoxicated with alcohol, cannabis and cocaine. (emphasis added)

73. In my view, it appears that the Trust's conclusion that there was *"…no root cause that could have prevented…"* my brother's death was reached because the Trust:

- Did not do adequate risk assessments during my brother's presentation/s
- Did not comprehensively consider medical records from previous attendances / different organisations/ GP
- Did not liaise adequately with the GP
- Did not take collateral history from family
- Did not assess his social situation and the extent of his substance mis-use

Essentially the Trust did not adequately assess or take into consideration the 7 'Patient Factors' mentioned in their own report.

74. The ***'Lessons Learned'*** section in the RCA report states:

> *"Whilst acknowledged that the Senior Social Work Practitioner assessed that no risk was identified based on information the Trust held and contacted the GP to verify contact details of Mr W. The Trust could have considered requesting a* ***police welfare*** *check to ascertain if there were any further up to date contact details."*

75. It is extremely concerning that despite all the concerns I have raised, and the RCA report has raised, why is this the only lesson learnt?

76. I have emphasised in bold below, entries from the RCA report which explain the organisations contacted and documents reviewed by those at the Trust investigating my brother's death.

> *"The Terms of Reference identified that contact be made with the* ***GP*** *to obtain information on his care in the previous 6 months and the* ***Priory*** *to determine if the patient was due to be admitted. During the* ***meeting with the family*** *on 5th June 2019 the investigators were advised that by the brother and sister that following Mr W's death they had located correspondence in his property that indicated he may have been scheduled to have* ***brain surgery*** *on 16th April 2019, the day following his death.*

Letters were sent to the GP, The Priory and Basildon and ***Thurrock University Hospital*** *on 18th June 2019 requesting a summary of any care provided in the 6 months preceding. This was followed up by telephone calls requesting information to help inform the investigation on 27th June 2019, 2nd July 2019 and 4th July 2019. Investigators have* ***to date not received any response****. However, confirmation was found in Trust records that contact had been made with the Priory and there was no planned admission. Copies of* ***GP records*** *from* ***Systm One's shared care record*** *were obtained by investigators and it was recorded within these that Mr W had informed the GP* ***' thought had stroke but diagnosed with lesion on pinela (pineal) gland he says'*** *the GP notes had no record of receiving any correspondence of this diagnosis. There was however a letter from* ***Basildon & Thurrock Hospital*** *dated 18th April 2019 advising that Mr W had failed to attend his stroke follow up clinic appointment on 15th April 2019.*

In the absence of being able to obtain information from the above organisations the investigators were only able to refer to Mr W's shared care records on Systm One which detailed his care under his GP in relation to any recorded brain surgery, clinical evidence suggests that if it had of been a major concern the neurologist would have taken further action and there is no evidence of this in the records investigators obtained. ."

The tragedy is why this effort to contact other organisations and the family was not made when my brother was alive? In addition, it is concerning if my 'brother died so close to the date for possible brain surgery. I would like the inquiry to look into the possible link between his mental state and brain surgery date.

77. **<u>Other points of concern</u>**

The RCA report further states :

"During the investigation some issues with ***record keeping*** *were identified, whilst having* ***no impact*** *on this incident or the care and treatment of the patient it was felt that they should be highlighted for learning.*

The Autopsy Report and Toxicology Report have Mr W's date of birth and age recorded as 13.12.1983 and his age as 35, it is believed that this is a typographical error; the identified errors were relayed to the Serious Incident Team who liaised with the Coroner's Office; they confirmed the date of birth the Trust held (13.02.1983) was correct and their records would be rectified.

*Investigators reviewed records outside of the Terms of Reference to ensure the **history of the patient was accurately reflected in the repor**t, whilst doing so it was identified that there were **errors in the date of birth** in some **Trust records**. As detailed above it was established that this was typographical errors. The content of the records were cross referenced with other records held and the GP shared care Systm One records to ensure that this was an error and not another patient with the same name. It was established that these were typographical errors.*

*Investigators also identified that the previous North Essex Partnership University Trust's systems Mr W had **registered the patient twice** with **two remedy identifiers**. 1 that had used his full Christian name and 1 that had used a shortened version of his Christian name. This has been highlighted to the records system team to investigate how this has occurred and to ensure that the records are now combined." (emphasis added)*

My comments on this:

78. If, whilst my brother was alive, the Trust tried to identify my brother's history, given the above errors was there a risk that my brother's accurate and full history may not have been located? This is so dangerous.

79. Document stated "Serious Incident E131007 Action Plan (EPUT) states on the last page *"Please note: this action plan will be audited following completion to ensure staff are supported with ongoing learning and implementation"*

80. I would like the inquiry to look into whether this happened.

Document entitled 'Questions from report on Terry White' further to receipt of the RCA report.

81. Further to Terry's death, I had two meetings with EPUT. Nothing substantive happened at the first meeting and I was told that the Trust would complete an RCA report. Further to the receipt of the same (in 2019), I prepared a document entitled 'Questions from report on Terry White' and sent this to EPUT in the hope that I would get answers to my questions during my second meeting with EPUT. All my comments seem to have fallen on deaf ears. No action was taken further to this meeting.

82. I do not believe that my questions were ever fully answered and so I have re-produced the contents of the above document in rule 9 statement, in the hope that the Inquiry will seek the answers I never got. The inquiry will note that I had asked EPUT for the Mental Health Trust Suicide Policy. I have to date not received this. I am of the view that Inquiry would be interested in finding out:

- Why my questions looking into my brother's care were not fully addressed?
- had they been addressed, would changes have been put in place for those with problems like what my brother had and
- If so, would this have prevented suffering for patients who had similar problems as my brother.

Below are the contents of the document with my questions I sent to EPUT :

"Questions from Report on Terry White"

- "Is there a Mental Health Trust Suicide Policy? I couldn't find it.

- What were the assessment procedures / questions when Terry was assessed by the mental health team? Especially after suicide attempts? Were his notes read thoroughly enough? (Eg – history of anxiety and depression, previous overdoses, involvement with criminal justice system, recent bereavement of his mother , mounting social stressors, possible personality disorder, unemployed, living alone, main carer for his disabled father, early childhood trauma, periodic access to drugs and alcohol services etc) How much of the bigger picture and whole story was taken into account? I feel that there must be some shame to what patients have done after a suicide attempt and I believe they may say they now feel ok because they are embarrassed and want to get home to where they feel safe, even though they may not be safe. At this point, if previous notes have been read thoroughly enough, the family's opinion should be sought.

- Why were family not contacted or asked for an opinion in each of these incidents? I did in fact speak to someone by telephone from the mental health team who had assessed him and my opinion was not taken into account. I called them. I said I believed Terry should be sectioned and that he was a danger to himself as well as other people. I explained that he would end up killing himself or someone else. My opinions were dismissed and I was told as he was speaking rationally there were no grounds to section him.

- When someone is begging not to be discharged as they say they will go and attempt suicide again, what are the grounds for discharging them? This

happened the last time he was in hospital. I was on the phone to him the whole time and heard him asking the nurse to please let him stay and help him otherwise he couldn't see a way out. I heard the nurse tell him 'there's nothing else we can do'. I told him to wait there and keep asking. He stayed for hours and kept returning to the nurses station and asking for help which was not given. Why was he not given the time for another assessment at that point?

- What was the involvement from the community psychiatric nurse team? Why were they not involved?

- Was there any communication with the Criminal Justice Liaison and Diversion team?

- For someone who ticked nearly all the boxes for being the most high risk (history of anxiety and depression, previous overdoses, involvement with criminal justice system, recent bereavement of his mother, mounting social stressors, possible personality disorder, unemployed, living alone, main carer for his disabled father, early childhood trauma, periodic access to drugs and alcohol services etc) why did it take so long for an appointment with the FRT? (18th March – 17th April is a long time for someone who is high risk).

- Tery didn't understand his mental health needs and taking drugs was a way of self medicating. The focus was on his drug taking an not on his mental health."

"From the investigation report – He was provided with information by Synergy to self- refer to Open Road. Mr W became verbally abusive and the team were unable to make any meaningful plan due to his resistance and declining offers of support available and he was discharged back into the care of his GP."

"Terry had been to open road before and said it was not helpful. He knew he needed more intensive help and knew open road wouldn't address this. Would it have been helpful at the time to signpost him or refer to other services at this point? (Eg counselling, trying to bring the psychiatric appointment forward?

- When Terry was seen by the RAID team on 15th January and declined help and support, what were the next steps? What happens when you know someone is high risk but they decline help? Or is it a case of him slipping through the net with no follow ups?

- Why did the FRT duty senior social worker not attempt to contact Terry's family when they couldn't contact him on finding out that he had ticked a box saying that he was suicidal? Next of kin contact details were on the system so why weren't family contacted?

- In the recommendations from the report:"*"1. Teams need to ensure that a full record of all assessment of mental state, risk to self and others and advice is*

recorded, even when patients decline full assessment and are difficult to engage. –"

- *"What does this mean? Include communication with family?*

- From the report –" [In italics]: *"The Senior Social Work Practitioner advised investigators that she has not assessed this contact as an urgent risk due to referral from the GP in March 2019 which did not indicate any suicidal ideations."*

  "What did the GP mention in his / her referral? Surely a patient referred to MHS who has been suicidal before is still high risk?

- From the report –" [In italics]: *"The Psychiatric Liaison nurse advised that Mr W presented with insight into needing help with his drug dependency and that he did not have any concerns regarding mental health issues through his presentation. He was not acutely mentally unwell or displaying any psychotic symptoms and he was able to articulate that he wanted help with gaining access to rehab, and not for his mental health. As Mr W had declined further assessment he was referred back to his GP and discharged from services."*

  "Terry was not displaying psychotic symptoms at this time. However, many psychotic episodes have been recorded by family and police in the past (see news report which highlights this – I will bring this to the next meeting) Terry was not the most aware of mental health issues in general and didn't understand his mental health needs. He saw it as a drug problem, despite frequent psychotic episodes, He thought having a mental health need carried a stigma and was keen to not been seen as 'mental'

- Crisis Resolution Home Treatment Team – why were they not involved following suicide attempts?

- From the report - "*The CPN had acknowledged that Mr W had a known history of cocaine addiction and impulsive overdoses whilst under the influence of drugs. He refused the offer of mental health screening advising that he only wanted help to be released from custody so that he could drive to Norfolk to scatter his mother's ashes that afternoon.*

  "Of course Terry wouldn't want to participate in any mental health screening as he was desperate not to miss the scattering of his mother's ashes. How was this followed up? Did the CPN have access to terry's notes? Contact GP for further information?

- From the report –*"Following medial treatment being administered by Basildon Hospital Mr W was medically cleared and referred to the RAID team for low mood.*

"Where is the evidence of my telephone conversation with the doctor who assessed Terry? As I mentioned before, I clearly raised my concerns about Terry being a danger to himself as well as other people but my opinions were dismissed. I stated that I, as well as other family members and his partner, were adamant he should be detained under the MHA but again we were not listened to.

- From the report *"The telephone call to FRT duty on 16th January 2019 from Mr W's partner was received by the same CPN as the call to FRT Duty on 11th January 2019. Mr W's partner was expressing her concerns about his mental health state. Mr W's partner advised the CPN that he has been seen by the RAID team at Basildon Hospital A&E department and discharged having been offered help but declined. The partner further advised the CPN that she had raised concerns with the police who had undertaken a welfare check that morning and reported back to her that he was fine. The partner continues to express her concerns about Mr W's suicidal thoughts and potential risk of overdose.*

  "Again, where is the evidence of communication and warnings from partner and family? How do you follow up with patients who don't engage?

- From report –" [In italics]: *"Investigators noted entries in the GP shared care records on 5th April 2019 that they had also been contacted by the DWP, the notes are unclear of the reason for the call, however the notes state 'it became clear that they needed to speak to mental health services' and they provided contact details. This contact with the GP would not have been known by the Senior Social Work Practitioner. In light of this Investigators reasoned that it may have been beneficial for her to have alerted the GP so as this concern could have discussed with Mr W contacted or attended his GP surgery."*

  "Were any recommendations passed on to her line managers about this as it's a pretty big error that the GP could have helped resolve?

- From report *"Although Mr W was noted to have capacity in his contact in A & E and his threats to commit suicide seemed in response to not being referred to Rehab there is no clear documented assessment of his mental state or a comprehensive documented assessment of risk to self and others."*

  "Why wasn't an assessment done? What are on the notes?

- From report–*"Mobius records were available that documented previous presentations in to A & E in December 2017 when a comprehensive risk assessment was documented as well as collateral history from contact with his half-sister, along with previous assessment from October 2016 again following A & E attendance with overdose at Basildon Hospital. These add depth and breadth to understanding Mr W and his difficulties.*

"Why were these not seen by staff before to help information gathering to gain a better understanding of Terry's difficulties?"

"There is no root cause that could have prevented Mr W's death."

"Seeking communication with his family and understanding his family's opinions would have been crucial here as well as having a keyworker or someone who could be an advocate for him, knowing the full history of his struggles.

In times of a serious lack of funding in the NHS, do you use an advocate system for people who are difficult to engage?

We would like to have more of a say with regards to the action plan / SMART recommendation but would really like to discuss this further with you in the meeting."

Points I would like to make with regards to EPUT's Investigation process / support provided

83. It appears to me that the RCA report states that the investigation team (into my brother's death) consists of staff who worked in the Trust, namely:

    - Legal Services Manager in the Trust for 3 years
    - A consultant in the trust for 15 years

84. There is no independence in this route and therefore will result in families having little confidence in the process

85. In any event, as stated in the RCA report, the process after my brother's death was as follows:

> *"The FLO has continued to maintain regular contact with Mr W's brother; she made a call on 7th May 2019 to ask if he would like to meet with the investigators to contribute to the investigation and report and brother confirmed he and his sister would like to meet with investigators. On the 20th May 2019 the FLO contacted the brother to agree a date and locality for meeting with investigators and made a further offer of support to him and his sister. He advised that his sister had already approached a bereavement service. Brother advised if he*

wanted to consider counselling that the FLO could offer support with this.

On 31st May 2019 the FLO contacted the brother to confirm arrangements to meet with investigators on 5th June 2019 at the Trust head office. The FLO extended an offer for the family on whether they would like Mr W's partner to attend the same meeting.

On 5th June 2019 Mr W's brother, sister and niece attended Trust head office to meet with the investigators supported by the FLO. On 6th June 2019 the FLO contacted the brother to confirm the addresses for making a request for copies of medical records from our organisation and Basildon & Thurrock University Hospital.

A telephone call was received by the FLO on 10th June 2019 from the brother asking if we could support his daughter who attended the meeting on 5th June 2019 to access counselling, the FLO made the necessary arrangements for IAPT to provide counselling services. A further offer of support was extended to brother who declined at that time.

On 14th June 2019 the FLO contacted niece to discuss the counselling and provide copies of referral forms."

86. The RCA also states:

"5th June 2019 – Investigators ***met with the family*** *at Trust head office and offered apologies and condolences on behalf of the Trust and thanked them for agreeing to meet. They informed investigators that Mr W had a heart of gold and was very good at disguising how he was truly feeling and good at pretending everything was ok; he was not always truthful about what was occurring in his life. His sister described him as being vulnerable. He had a very close relationship with his mother and was in frequent contact with her until she passed away in October 2016.*

The family advised investigators that although Mr W was recorded as being a carer for his father he very rarely visited and that they had always had a difficult relationship.

They described Mr W as having difficulties from a young age and being diagnosed with ADHD at 16 years, (this is recorded as 17 in a number of his clinical records).

Mr W's brother advised investigators that they had not spoken for around 6 months due to Mr W's paranoid belief that he was planning to kill him. Mr W's sister also disclosed that they had not spoken for a month prior to his death. His niece told investigators that she had a close relationship with her uncle and he had been in close contact with her during the last year.

All the family were understandably tearful at the meeting particularly his niece who confirmed she was struggling to deal with her uncle's death. Support from the Trust was offered and was accepted by her following this meeting; she was assisted by the FLO to be referred for counselling on 14th June 2019 following a call from her father to the Trust on 10th June 2019.

The family provided helpful information to the investigators that was not documented within Trust records; *Evidence that Mr W had been using steroids as a weight training aid were found by his brother in Mr W's flat following his death.*

The family disclosed that they also found documents in Mr W's flat that indicated he may have been scheduled to undergo some sort of brain surgery on 16th April 2019 at Basildon & Thurrock University Hospital; further notes were located by the family in his flat that had handwritten reference to cancer. The family had no knowledge of any operations or medical treatments that Mr W was undergoing and were concerned that this may have had some impact on his decision to end his life.

They expressed their concern as to whether assessments were thorough enough. Mr W's brother queried ***why Mr W had not been found to be detainable under the MHA in light of the paranoid ideation that he had been expressing to him****. They were concerned that Mr W was just seen as*

an individual with drug problems and not being taken seriously enough in relation to his mental health and ADHD; they were concerned whether any medication and treatment was being provided for his diagnosis of ADHD.

The family wanted to know what support, care and treatment he was offered ***after overdose attempts****, what happened when patients did not engage, if the patient was offered any counselling and* ***why he was not sectioned.***

The family were keen to identify any learning or training needs from the investigation. They state that Mr W had said that he was advised at Basildon & Thurrock University Hospital that ***there was nothing else that could be done for him.***

87. **My comments on this**

88. It is stated above "***The family provided helpful information to the investigators that was not documented within Trust records".*** This reiterates the point already made that it was essential that the Trust contacted the family, when my brother was alive, to obtain a collateral history.

89. I am concerned that the RCA states:

> *"The FLO was appointed and made contact with Mr W's brother on 3rd May 2019 to offer condolences and explain the Serious Incident Investigation Process and offer to provide support as required. Apologies were provided for the delay in contacting him* ***as The Trust had been waiting for the NOK details from the Coroner's office****."* (emphasis added)

90. Does this mean that the Trust did not have the NOK's details on the file. If not, why not? I would also like to add that no support was provided by the FLO.

Final thoughts and Suggested Recommendations

91. Terry was deaf when he was little as he had measles. He could not hear properly until he had grommets fitted. This affected his learning at school and self-esteem. He also had dyslexia. He had been diagnosed at a young age with ADHD. I believe that he did not get this diagnosis until he was 16 years

old. I do not believe that any further substantial help was given once diagnosed with ADHD. Why? Would it have made a difference if he had been provided? Were these factors ever taken into consideration when being assessed for his mental health and risk? If not why not?

92. From what I know when Terry first started to feel mentally unwell, his parents called the Samaritans for assistance as I think that there was not any Community Psychiatric Nurses around at that time. He lost his mum in 2016 I believe it was then that he deteriorated and I think he was unable to work after this. He started to do more cocaine.

93. There had been several suicide attempts, some of which are mentioned above.

However, there were additional attempts such as when Terry :

- tried to jump off his roof and riot police were called to his house.
- tried to hang himself a couple of times.
- was naked trying to jump off a balcony - police were called to his house.

94. I do not recall the exact time as to when the above incidents happened. I do however remember that the above incidents were on the front page of a local newspaper.

95. I would also like to add that there was one occasion when Ellie White (Terry's niece) attended Terry's property when he tried to take his life. I have a vague memory that this may have been when Terry tried to jump of a balcony. In any event, the police were present at the scene. Ellie recalls having spoken to a sergeant and asking him to do something to help Terry with his mental health given what Terry had done that day. The sergeant informed Ellie that he would do something to help Terry. Nothing was done, in fact the same sergeant attended Terry's residence after Terry died. When Ellie (who reached Terry's residence after he had died) asked the sergeant why he hadn't done anything to help Terry despite reassuring her previously saying he would, he denied that he was even present during the previous occasion when Terry had tried to take his life. He eventually later accepted that he was in fact present on that previous occasion.

96. In addition, the day Terry died, as well as Ellie, his friend **[I/S]** and Jamie Cox attended the scene. In fact, **[I/S]** was the first person to attend Terry's residence when he died. Terry had a strange relationship with his friend **[I/S]** For example, Terry had told me that he and **[I/S]** had agreed to 'help each other take their life'. We all felt that it was slightly odd that the police weren't thorough when it came to getting statements from those present on the day

Terry died. For example, the police did not take statements from Ellie, Terry's niece may have now in hindsight will have said in her statement that the police were aware of Terry's mental state and that they should have done something to help signpost Terry. Further, we as a family always thought Terry's friendship with [I/S] was slightly odd, and do not know how he ended up being at Terry's home when he died, especially as he had discussed with Terry about how they would both 'help each other end their lives'.

97. I would like to the inquiry to get hold of the police records pertaining to incidents mentioned above as this will help me see the incidents the police did make a note of and what they actually did about reported incidents.

98. Terry knew that he was mentally ill and was really struggling. He wanted help and it wasn't there for him. He needed therapy; simply needed someone to talk to about his problems and how to deal with them. Medical staff just told him to keep taking anti-depressants / anti-psychotic medication – how can this be the only solution? There is a lack of accountability and empathy with the medical staff.

99. In my view Terry's mental health problems were repeatedly dismissed by the Trust and I believe that this is because the Trust stereotyped him and saw him as a "druggie". I am sure that if I (as a teacher and more articulate than Terry) suffered with mental health issues and approached the Trust for help for myself, I would have received better care.

100. Terry lived alone so, for example, when Terry texted to say he was contemplating suicide we (myself/ my other brother [I/S] Terry's friends) would contact the police to do a welfare check on him. Paramedics would be contacted if Terry had attempted to end his life.

101. We as a family had to find our way around the police, ambulance, mental health services and A&E. We saw the traumatic episodes of psychosis and other severe mental health symptoms my brother suffered with. Our only aim was to try to get him inpatient treatment (via section if need be). We felt that it had to be inpatient treatment due to the chaotic lifestyle he led, his drug habits and his suicide attempts. But as far as I am aware he was never sectioned. Whenever Terry was admitted to hospital he would often be discharged soon after (either to the care of no-one or the GP). We would hear statements such as 'he had capacity' and was 'speaking clearly'.

102. I remember calling numerous times over the years and ask to speak to doctors and nurses but simply being told that they were too busy to speak to me. On the rare occasion that I spoke with staff I remember being told that there was nothing that they could do. I remember speaking with members of the mental health team and questioning why he was never sectioned as I told them he was a danger to others as well as himself. I was completely ignored. In my view there were numerous occasions over the years when Terry should have been sectioned. In fact, the psychiatrist on the internal investigation panel investigating Terry's death agreed that Terry should have been sectioned. During my second meeting with EPUT, the psychiatrist who attended this meeting said that he had seen people being sectioned for *'a lot less'.* I discuss this further below.

103. Various friends and partners have contacted mental health services to get Terry help but without much success.

104. I will never forget a particular event in 2019 Terry was in Basildon A&E after a failed attempt to take his life, and he called me stating that the staff were discharging him; he pleaded that I do not let them discharge him as he needed help and would go home and try again. I remember telling him to stay there if he felt unsafe and to tell reception. I stayed on the phone to him whilst he was being discharged. I remember hearing him begging the staff not to discharge him, as he would try again to take his life. He was asking to be sectioned. I overheard the staff member simply tell him that there was nothing further they could do and that they would send him a letter for his next appointment. I heard the receptionist in the end say to him that they would have to call security if he didn't leave the premises; this was all while he was crying and begging to be sectioned.

105. I do not understand how, even at the point of begging, no one took into account his whole story and gave him the help he so desperately needed. Terry ticked all the boxes to be admitted, but no one took the time to look at his whole history.

106. I remember frustratingly that for some of the incidents where the police were involved and Terry was clearly psychotic, nothing substantial appeared

to have been done for him other than to lock him in a cell for the night and send him home the following morning. In my opinion this highlights the failings in communication between mental health services and the police. I also remember that during a police welfare check, the police told Terry to '*smoke a joint and calm down'.* How is this appropriate? I believe that Terry needed a key worker / advocate who knew the full history of his struggles (including social issues) well. This should have taken place as soon as it was evident that Terry had many issues overlapping with each other (such as mental health with social issues).

107. This keyworker could :

- trace, check up on and monitor those who are difficult to engage.
- emphasise when matters were deteriorating
- during periods of stability encourage counselling, support groups
- ensure that there was better engagement with the families / ensure that a collateral history is obtained from the families.

In my attempt to make a difference, I asked if EPUT if I could join their family panel for suicide prevention. I was told they were extremely keen to get me involved. I was asked to become involved in the suicide prevention team, representing families. I was very keen to be involved but disappointingly I have not heard any further from them.

Further to Terry's death, I had two meetings with EPUT. Nothing substantive happened at the first meeting and I was told that the Trust would complete an RCA report. Further to the receipt of the RCA report, I made a lot of suggestions (i.e my questions further to the RCA report) in the second meeting I had with EPUT. All my comments seem to have fallen on deaf ears. No action was taken further to this meeting.

Request for Disclosure

108. In addition to any disclosure request mentioned above, I would like the Inquiry to obtain the disclosure, which is mentioned in the following extracts

from the RCA report: (Emphasis added). Where an interview was conducted please can the inquiry obtain a recording or minutes of the interview.

> *"This investigation involves using various methods to establish facts around the incident in form of* ***tabular time lines, witness interviews of staff*** *in contact with the patient in the 6 months preceding the incident; scrutiny of* ***records*** *within mental health and primary care sector."*
>
> *"Duty of Candour records"*
>
> *"Gather documentary evidence including full case records, statements and any other written evidence relevant to the investigation."*
>
> *"As a panel, conduct interviews or obtain* ***statements*** *from all relevant stakeholders and agencies including the First Response Team, RAID, the GP and The Priory if the patient was due to be admitted."*
>
> *'Consider compliance with relevant* ***local and national policies, procedures and statutory guidance*** *in particular management of risk and dual diagnosis.'*
>
> *'..****training staffing issues.. and the impact of organisational and pathway changes..'***
>
> *Clinical Records*
> *Trust policies and Procedures*
> *NICE guidance*
> ***Interviews with staff***
> *First Response Team Clinical Guideline April 2016*
> *FRT First Response Team Clinical Operating Procedures reviewed June 2017*
> *NICE guidance - CG 51 Drug misuse in over 16s: psychosocial interventions.*
>
> *As part of the investigation* ***telephone interviews*** *were conducted with the following members of staff:*
>
> - **[I/S]** *Senior Social Work Practitioner – 28th June 2019*
> - **[I/S]** *– Community Mental Health Nurse – 28th June 2019*
>
> *And a* ***face to face*** *interview was conducted with:*
>
> - **[I/S]** *– Psychiatric Liaison Nurse – 2nd July 2019*

102.I also do not have a complete set of medical records from the Trusts and GP and I would like the inquiry to obtain this.

109. I would like the inquiry to obtain the transcript of the inquest.

List of documents I have

- Incomplete medical records
- Root Cause Analysis Report
- Inquest bundle (incomplete)

Statement of Truth

SIGNED [I/S]

Ms Emma Harley

Dated :