IN THE LAMPARD INQUIRY

Witness name: Daniel Leader
Statement No. 1
Dated: 14.07.2025

WITNESS STATEMENT OF DANIEL LEADER

I, Daniel Leader, provide this statement on behalf of the Leader family in response to a request from the Inquiry Legal Team under Rule 9 of the Inquiry Rules 2006 dated 24 February 2025 and will say as follows:

Introduction

1. I am the brother of Joshua ('Josh') Leader who died on 24 November 2020, aged 35 (DOB: 23 April 1985). References in this statement to we, unless otherwise stated, are to members of my immediate family, namely my siblings and parents.

2. My brother Sam Leader separately provided a commemorative statement to the Inquiry on behalf of our family in the November 2024 hearings. I would ask that the Inquiry consider this commemorative statement carefully, and in conjunction with what is written here, as it provides a portrait of who Josh was as a bright and beloved brother, son, uncle and father to his son, beneath the mental health difficulties that afflicted him for so much of his life.

3. As set out below, an inquest was held into Josh's death at the Essex Coroner's Court in 2024. In preparing this statement I have had access to the documentary and witness evidence from the inquest, which I have referred to where relevant in order to best assist the Inquiry in providing as much information as possible about Josh's involvement with the Essex Trusts.

Background

4. I am the older brother of Josh, and there was a 13-year age gap between us. Our parents are Florence and Sheldon Leader. Josh and I have another brother (Sam, referred to above) and a sister (Anna), but Josh was the youngest in the family by some distance. The age gap between us meant that for a lot of Josh's life, we had a relationship that was often more akin to a parent/child one than siblings.

5. We grew up in Colchester, Essex. Josh, Sam and I went to a school in nearby Ipswich. Josh had a very happy childhood and was much loved and cared for.

6. There was an incident when Josh was around 12 or 13 years old which deeply upset him and which he would refer to throughout his adult life as a traumatic event. Josh was out skateboarding with some friends near to family house. They were outside a 'half-way house' when a man came out and screamed at them. He threatened them and urinated

on them. The man told Josh and his friends not to tell anyone he had done this. Josh came back home terrified. The police subsequently arrested the attacker, who later died in prison by suicide. This incident was a huge shock for Josh and the whole family.

7. Josh did very respectably in his GCSEs, and following this went to the Sixth Form college in Colchester. Unfortunately, after moving to sixth form, things seemed to begin to unravel quite quickly. I do not know the full details since I was living in London at the time, but Josh became involved in a 'bad crowd' and began taking drugs, in particular cannabis (including skunk). At some point during his sixth form studies, something seemed to switch in Josh's brain, and he had a total mental breakdown. He began displaying symptoms of serious paranoia and psychosis. As a result, he had to take a year out of his sixth form studies.

8. Around 2005 Josh first became known to Essex Partnership University NHS Trust ('EPUT'), and he became involved with their community mental health services. After taking a year out, Josh returned to sixth form at Ipswich School. He did poorly in his A levels, but went to Bath University to study graphic design. Josh remained very unstable throughout this period, and was generally very unwell. Josh found it difficult to go outside and socialise and was very anxious and insecure, which represented a major change in his personality because he had been a confident and happy child. He was given various diagnoses at the time, including schizoaffective disorder and a personality disorder. He continued to see a psychiatrist and access mental health services through EPUT. The family were in regular contact with Josh, seeing him, speaking to him regularly and supporting him through university.

9. After university, Josh seemed at a complete loss and continued to get himself into trouble. For a while he lived with me in London and I found him some work at a friend's tech business, but Josh found it difficult to function properly in society. Josh would come and go from my parents' house in Colchester and remained under the care of Essex mental health services after university and I recall the level of support was poor. I do not recall the dates or the precise details of various interactions with EPUT when Josh was younger, but I do have memories of difficult interactions with mental health services. I recall he once went to the Lakes in Colchester in considerable distress and with marks on his wrists where he had been trying to slit them but was then turned away and sent home without assistance. I recall numerous incidents of pleading with the crisis team for help when Josh was in crisis and being met with indifference and an unwillingness to assist. Josh reported that at one crisis team visit when he was clearly suffering from psychosis, he was told that there are many people in a much worse state than him and he should be more appreciative. On another occasion, I suggested to one of the services that it would be good if Josh could access support to get him into an activity with a view to eventually working, since there had been periods when he was well when he had been able to work and such activity was very good for his well-being. The response was that they did not have anything to offer him and that Josh should accept that he would not be able to work given his mental illness.

10. As a family we struggled with the mental health services in Essex for many years and getting the right support for Josh had proved impossible. Our mother, Florence, who is

French, had family who recommended a psychiatrist in France. Her family thought the mental health services may be better in France. As a result, Josh moved to France temporarily to take up the mental health services there. He lived near to Marseille and near to Florence's extended family who kept an eye on him. Josh stayed in France off and on for around 3 years; this was a period of relative stability for him. He was reasonably well cared for in France, with regular psychiatric appointments. Josh was on antipsychotic medication during this period, which he appeared to be compliant with.

11. In or around 2010/2011, he travelled to Peru. This became part of a pattern for Josh, who was very good at organising trips for himself usually connected with finding a solution to his problems. He had read about ayahuasca, a plant-based hallucinogen taken in Peru, which he thought would 'purge' him, and he went to a camp in the forest to take it. Our father Sheldon, became very concerned about Josh and the potential of him taking an overdose and sent our brother Sam to go and find him. Josh was found in a boarding house, in a catatonic state and showing signs of recent self-harm. After returning from Peru, we took him to A&E at the Whittington Hospital where Josh was sectioned under the Mental Health Act 1983 ('MHA 1983'); my recollection is that he was then transferred to Highgate Mental Health Centre in London (which was part of Camden and Islington NHS Foundation Trust) where he remained detained for a long period.

12. Following his discharge from the Highgate Mental Health Centre, Josh was feeling more stable and keener to progress with his life and get into work so he decided to move back to Colchester in Essex in around 2011. Josh was into mindfulness and meditation at the time, and he met **[I/S]** at a Buddhist centre in Colchester. Josh had a relationship with **[I/S]** and they had a son together, who was born in October 2012 and whose name is **[R/O]** . Josh lived with **[I/S]** for a period in Wivenhoe, but this fell apart quickly.

13. Josh decided he wanted to go to a Buddhist centre in upstate New York, and he left **[I/S]** to go there. However, **[I/S]** then followed him out there and they were together for a few weeks. I was contacted by the Buddhist centre, who asked me what was wrong with Josh as he was very unwell. The Buddhist centre thought that Josh needed to be admitted to hospital, and he subsequently spent several weeks in a psychiatric hospital in New York. After a few weeks, the American authorities wanted to get rid of Josh, so they paid for his flight and sent him to Marseille. I cannot now recall why he was sent to France and not the UK. Josh then spent a further period living in France, and his relationship with **[I/S]** broke down permanently.

14. From around 2015, while Josh was living in France, he initiated family court proceedings in Essex over access to his son. He was back and forth to Colchester and Chelmsford. This was a difficult process for Josh, but he managed it admirably. Josh continued to receive the support of French mental health services during this time and to take anti-psychotic medication. He appeared to remain relatively stable throughout. The family court proceedings took two years but ended with an order for Josh to have contact with his son every two weeks for the whole weekend, which he was happy with. Josh then decided to move back to the UK permanently so he could see his son regularly,

however he kept a bedsit in France, and I understood he remained to some extent within the French mental health system.

2018: First EPUT Inpatient Admission

15. On returning to the UK, in around late 2017 or early 2018, Josh moved to a communal house in Islington. Josh organised this accommodation himself, which I understood to be a kind of therapeutic community run according to the ideas of a well-known psychiatrist [I/S]. This placement was very poorly run and a disaster for Josh, and it broke down after 6-8 months. Josh stopped taking his antipsychotic medication and became very unwell in this period, presenting with what were by then familiar symptoms to my family and me.

16. By this stage, we had seen Josh's mental health fluctuate on many occasions. When deteriorating – precipitated by his non-compliance with his medication – it was common for Josh to speak increasingly about people targeting him. For example, when he first became ill, he said he felt that people were revving their cars down the road just to upset him (which was something he had said since his adolescence), or that he felt otherwise unsafe and that people were hostile to him because of his appearance. He was particularly concerned about his perceived lack of masculinity and became convinced that he had a genetic disorder, not a mental health problem. He would also become obsessed with wanting to flee or escape his current location, often abroad, and often because he had decided he could find better treatment or a better life. Around this time, we went on holiday as a family with Josh's son, however we felt that Josh was too unwell to see him, so he didn't come.

17. One night when Josh was staying in France during the summer of 2018 (he had been back and forth from France throughout this period), he sent a text to our parents saying that he was beginning to have suicidal thoughts. Our parents immediately contacted the French police who went to Josh's flat in the middle of the night. My parents and I also went to his flat. Josh told the police he was ok and did not actually intend to take his own life. However, following this incident Josh was again admitted to a psychiatric hospital for around 10 days in France. While admitted, Josh began taking his medication again and stabilised sufficiently that the psychiatrists felt he could safely be discharged.

18. Following his discharge from hospital in France, Josh then moved back to Colchester near to our parents for a short period. However, shortly after returning to the UK, Josh again stopped taking his medication and again became very unwell. There was an incident where Josh was in Colchester town centre with our mother, where Josh began speaking with a Scottish accent and quoting scenes from Macbeth. His behaviour was erratic and his familiar symptoms of paranoia, believing people were after him and that he had some kind of genetic disorder returned.

19. It was clear to us all that Josh was relapsing again. On 28 August 2018 we therefore wrote, as a family, to Josh's then EPUT psychiatrist [I/S] (who was based at The Lakes Mental Health Hospital) requesting that he be admitted to hospital and detained under the MHA 1983 as we were so concerned for his wellbeing in the community. In this letter

we described how Josh "*now suffers from multiple delusions, paranoia, extreme mood-swings, various persecution complexes, aggression and suicidal urges*." We also described examples of Josh's recent concerning behaviour, which included:

> "*He is currently convinced that he suffers from Kleinefelter's syndrome and despite being tested for this condition, he maintains the doctors are anti-semitic and therefore will not diagnose him correctly. He furthermore insists that his family have known about his condition for some time but have withheld the information from him as a means of control.*
>
> *Less than a week ago he was found in the street outside the house he was staying, claiming he was blind and needed help.*
>
> *A month ago he bought a one-way ticket to Israel believing he will be better treated there despite having no resources to support himself nor any contacts. Scared, he contacted his family who convinced him not to take the flight. Police present at the airport accompanied him to a taxi which brought him to a family member's house.*
>
> *Since his release from hospital in France he once again stopped taking all medication entirely and has completely relapsed. He has also been taking various 'homeopathic' drugs in large doses, which have had a seriously deleterious effect on him."*

20. The letter made the family's view clear, writing that "*we feel strongly that Joshua must be detained for long enough to stabilize on his medication; otherwise we will see an unending cycle of successive delusions and extreme behaviour, and he will continue to pose a threat to himself and to others*", and further that "*[h]istorically after a period of taking his medication he gains insight into his mental condition and is able to care for himself and relate well with his network of friends and family*." The medication we were referring to was antipsychotic medication.

21. Following this, in late August 2018, Josh was admitted as a voluntary patient to Gosfield Ward, The Lakes Mental Health hospital, under EPUT. Josh himself agreed to be admitted until the right medication to stabilise him could be found.

22. Josh was an inpatient for several weeks until 10 September 2018, when he was discharged. I was away in Canada with my wife and daughter during this admission and, although in regular telephone contact with my family, at the time my mother was more involved with Josh's care. At the time of his discharge, Josh was prescribed Amisulpride (an anti-psychotic) as well as Sertraline (an anti-depressant) and Clonazepam (a benzodiazepine).

23. Following discharge from The Lakes, Josh was on and off his medication, and he 'floated' around a bit. He again spent some time living in France over the next 12 months

but also had a place he could stay in London, as well as sometimes staying with me and my family there. Our father Sheldon was diagnosed with Stage 3 Lymphoma in late 2018 and I wanted to largely keep the stress of supporting and managing Josh away from my parents during this time, and so I began to take a more active role in his care and treatment. From around this point, I became the member of family with primary contact with Josh.

Early 2019: Admission under the MHA 1983 in London

24. In around late 2018 or early 2019, Josh again became very unwell again. I do not know if he was taking his medication at this time (it was difficult to monitor this given his itinerant lifestyle), but I suspect he was not. Josh believed that he was hated and persecuted because he was half-Jewish and would repeat often that this was the source of his problems. These beliefs became more heightened during this period, and he returned to the idea that he needed to flee, this time to Israel, where he believed he would be more welcome. Josh had only ever been to Israel once on a school trip and he had no connections in Israel. Despite this, Josh put himself on a flight and went to Israel. On arrival at the airport Israeli officials assessed him and decided he was very unwell. They strip searched him and put him in a cell. They then put him on a flight to France, and I then arranged a further flight for Josh back to London. I and my brother Sam met Josh at the airport and we took him straight to University College London Hospital ('UCH'), which was the closest A&E to my house, where Josh was then admitted and detained under the MHA 1983.

25. Josh spent much of early 2019 as an inpatient in London, first in a mental health facility in Kings Cross, and then, from late May until August 2019, back in the Highgate Mental Health Centre, on the Dunkley and then Emerald Wards. Josh was very unhappy in hospital and wanted to be discharged, but his psychiatrists were clear that he was extremely unwell, and there then followed a series of mental health tribunal hearings. This was an incredibly fraught time and I was very involved with Josh and his treatment, and the primary contact with his mental health professionals, who I found at this time took Josh's condition and any concerns I had very seriously.

26. I recall one inpatient meeting around this time that I attended with six healthcare professionals, including Josh's psychiatrist and care coordinator. I was informed by the professionals involved in Josh's care that they were very worried about him, and they described how Josh would often present as 'normal', but under the surface was very unwell and continuing to suffer with the same psychotic symptoms. By this I mean the symptoms I have already described above – wanting to escape, believing it would make things better or to find what he thought was a solution or treatment, extreme paranoia about people wanting to get him, and fixating on having another undiagnosed physical or genetic illness/disorder. The professionals explained how Josh continuing to be detained under the MHA 1983 was avoidable, but to avoid detention he first needed to stabilise, in particular to have a period of being compliant with his medication. We all agreed with this and it fit with the relapsing pattern that had been clear to me and my family for years. Namely that the moment Josh stopped taking antipsychotic medication things began to spiral out of control for him, and that he could become very unwell but

appear as 'ok' to those he met. In contrast, when Josh was taking antipsychotic medication, it made a big difference and he was much more stable, gained insight into his behaviour and his symptoms greatly reduced.

27. At this time, while Josh was still in hospital in 2019, my main focus was to solve two problems: Josh's accommodation (so that he would not return to live with our parents who could no longer cope with his erratic behaviour), and also how to ensure Josh kept on taking his medication. I felt strongly that if those two things could be resolved meaningfully, that Josh could stabilise and then improve, as he had done previously when suffering similar symptoms.

28. During preparations for Josh's discharge from Highgate Mental Health Centre, I attended numerous meetings with his psychiatrist and the ward manager, and I also attended a formal discharge meeting. A theme in many of the meetings I attended around this time was that I understood Josh was entitled to a s.117 MHA 1983 aftercare assessment, plan and funding, as he had been detained under Section 3 of the MHA 1983 or a period more than 28 days. I had looked up s.117 aftercare on the NHS and Mind websites, and I understood it to mean that Josh was entitled to receive a full and thorough assessment of his needs and a long-term plan for his care involving a family consultation which engaged the various services and teams involved in Josh's care, and led to appropriate psychiatric supervision. I thought that this was exactly what Josh needed to break the vicious cycle he was in. My biggest concern was that the pattern of non-compliance with medication and repeated serious relapses could be stopped with the right support and oversight. I thought a proper s.117 assessment and aftercare was exactly what he needed.

29. Unfortunately, despite me raising concerns repeatedly, the accommodation and medication plan was not fully in place when Josh was discharged around July 2019, and no s.117 aftercare had been arranged.

30. On 2 August 2019, Josh was discharged to temporary accommodation, a hotel in Hampstead. I had initially been very worried about Josh staying at this hotel and how he would cope but he seemed to be fine there. Josh was taking Aripiprazole, an antipsychotic medication, at the time. There then followed a period where I was coordinating with mental health professionals in Islington, and was in contact with the council to try and arrange longer term accommodation for Josh. I had little success although Islington eventually agreed to provide him with some further temporary accommodation. In the end, as the situation was getting desperate, our parents agreed that Josh could come back to stay with them in Essex, and I began to arrange this move instead.

November 2019: Transfer back to EPUT mental health services

31. Josh was subsequently transferred from the care of Camden and Islington NHS Trust back to EPUT in early November 2019. Josh was then referred to the EPUT North Essex Specialist Psychosis Team.

32. I remained in contact with Josh's psychiatrist in Islington, Dr [I/S] as I was concerned that the s.117 aftercare had still not been arranged for Josh. The Islington mental health services were clear that they had no power in this respect as Josh had decided to move away from the Trust, but they could communicate the position to EPUT. This led to Dr [I/S] writing a letter on 25 November 2019 to the North Essex Specialist Psychosis Team, which was copied to me. This letter stated:

> "*My service assessed Mr Leader in October of this year (within a framework that is compliant with the Care Act, 2014), and appraised that he had needs requiring S117 aftercare. That is, that on-going mental health input would be appropriate from one of our psychosis-line services, and that he had further needs that could be met within a supported accommodation environment (to which we referred him before he decided to move to Essex).*"

33. The letter went on to say that an arrangement could be put in place with Islington services regarding funding the s.117 aftercare within EPUT. As I will explain later, this plan for s.117 aftercare never emerged.

34. For the next few months Josh lived with our parents. Josh was compliant with his medication and doing well, better than I had hoped, through to Christmas 2019. He was going to the gym regularly with a lodger who lived with our parents, and was regularly seeing his son. My family hosted Christmas in London. Josh was on great form, and we all had a lovely time.

Early 2020: Further Deterioration in Josh's Mental Health

35. In early 2020, Josh moved out of our parents' home and into [I/S] which was round the corner from our parents in Wivenhoe. Initially this move was fine for Josh, who lived with a flatmate and seemed to still be doing well.

36. However, shortly after moving into the new accommodation, things began to again deteriorate for Josh. He stopped taking his antipsychotic medication in around March 2020. Josh began to show clear signs of wanting to 'flee' again. He asked professionals involved in his care to help him with a visa letter so that he could go abroad, I believe he wanted to go to Israel again. Josh remained obsessed with Israel and fleeing there, and that if only he could move there things would improve for him. Following his last trip to Israel Josh thought he had been blacklisted from visiting again, and he found some Israeli lawyers to try and get himself unblocked. I do not think that these attempts went anywhere but Josh did pay the lawyers some money. The onset of the COVID-19 pandemic however cut short Josh's plans to travel to Israel.

37. Throughout the first COVID-19 lockdown in early 2020, I did not have any in person contact with Josh since I was in London and travel was not permitted, but he was in regular phone contact with me and the rest of the family. Josh said that he found it hard to be on his own but that he was doing OK. He kept busy by shopping for elderly family

friends and walking their dogs. My general impression of Josh at this time was that he was holding it together, even if showing some psychotic symptoms and struggling with taking his medication as prescribed.

38. I have since had sight of entries in the EPUT medical records which indicate that, by March 2020, Josh was again in crisis. I note an entry on 17 March 2020, which records that Josh called [I/S] his care coordinator, to report that he was not well, stating he felt suicidal, and had stopped taking all his medications several weeks earlier. In this call, he asked CC to arrange hospital admission for him and/or an urgent review by the team's psychiatrist as he was unable to judge his current mental state. It appears that Josh was seen the following day, 18 March 2020, for an urgent review by Dr [I/S] (a consultant psychiatrist within the Specialist Psychosis Team) during which he is recorded as reporting suicidal thoughts with a plan to gas himself. Josh's antipsychotic medication was reviewed and changed from Aripiprazole to Olanzapine. He was then referred for assessment by the Home First Team, who saw Josh on 19 March 2020, however, as he declined to be assessed, they referred Josh back to the Specialist Psychosis Team.

39. On 10 April 2020, our mother telephoned emergency services after Josh said goodbye to her and that he was going to end his life that day or the next. Josh had totally stopped taking his medication and was very unwell. He was convinced that the medication was harmful and that in reality his illness was physical, not psychiatric. He was telephoning our mother over 40 times a day in a state of severe distress. I telephoned EPUT's Specialist Psychosis Team, to report my concerns and Josh's deterioration. I also sent a text to **his CC** stating that:

> "*He* [Josh] *is freaking out and not taking his meds. I am stuck in London and we are afraid he will do something silly. We have tried to call the crisis team but they have said they are shut over the bank holiday !!*"

40. I understand that following this, Josh's care coordinator spoke with Josh and a medical review with his psychiatrist was arranged for a few days' time.

41. On 15 April 2020, I sent a further text message to **the CC** stating:

> "*Josh had a very bad weekend and an ambulance had to be called because he threatened suicide. He seems better now but it could spiral out of control again at any minute. What can be done? I am stuck in London.*"

42. On around 17 April 2020, Josh explained to me that he had attended an appointment with Dr **[I/S]**, who had decided that Josh should come off his antipsychotic medication (by then Olanzapine) due to side effects he was reporting. As Josh wanted to stop taking the anti-psychotic medication, he would complain of side effects when he spoke to his doctors, even though he had previously taken Amisulpride for many

months without complaint. I sent a text to Josh's care coordinator [I/S] on 17 April 2020 stating that I was very concerned about this change:

> "*Hi* [cc] *- apparently Josh spoke to the psychiatrist who told him to stop taking his medication! Is that correct? Can I please speak to his psychiatrist urgently? I am worried that he needs to be on his meds and the fact that he has not been taking them has caused this current spate of serious instability.*"

43. I believed that by this point Josh was demonstrating the familiar psychotic symptoms we had now long experience of. His behaviour was erratic, he was worried people were hostile to him and wanted to target him, and he was expressing suicidal thoughts. I felt it was very important to communicate to the mental health professionals that his deterioration was part of a clear pattern, long recognised by us as his family and previous clinicians involved in his care. I was very concerned that Josh had been taken off antipsychotic medication when I had made it clear to all professionals I had interacted with since Josh moved to Essex that he significantly deteriorated when not taking antipsychotic medication. Following this, [the CC] told me that Josh's psychiatrist would call me to discuss the change.

44. On 20 April 2020, I spoke with Josh's psychiatrist, Dr [I/S] by telephone. I think this was the first time we spoke. I explained to Dr [I/S] that while Josh was not at that precise moment in crisis, I still had significant concerns about the possibility of this spiralling out of control quickly if he was not taking antipsychotic medication. I made clear I was therefore very concerned about Dr [I/S] decision a few days earlier to take Josh off anti-psychotic medication. Dr [I/S] did not appear to have read any of Josh's medical notes as she seemed entirely unfamiliar with his medical history. I explained to Dr [I/S] that Josh had a long history of struggling to stay on his medication and then rapidly deteriorating when he stopped, and I also explained that Josh still needed s.117 aftercare to be put in place. We also discussed finding Josh productive ways to use his time and get him active, which I also believed would really help him. I remember clearly that Dr [I/S] described Josh to me as a "*very interesting case*". I understood that following this call, Josh would be re-prescribed Aripiprazole antipsychotic medication and that he would be referred for psychological intervention.

45. Soon after this, Josh sent me a message stating that he had spoken to his psychiatrist (which the records indicate also took place on 20 April 2020) who had prescribed him a low dose of Aripiprazole.

46. Unfortunately, fairly soon after, Josh stopped taking his antipsychotic medication again. I note, from evidence received in the inquest, that Josh saw Dr [I/S] again on 5 May 2020, by which point he reported he had already stopped taking the Aripiprazole and that he was not well. He listed a serious of complaints including believing he had a 'genetic' problem, that he had failed at life and had nothing to look forward to. Josh reported he was due to have a blood test for testosterone the next day to verify whether or not he had 'hypogonadism', and that he had recently started an online 'Dynamic

Neural Retraining System' which he believed to be a drug free way to retrain his brain. Josh appears to have himself accepted at this meeting that his obsessive thoughts of "*being genetically deformed*" may be part of his psychosis.

47. On or around 6 May 2020 I had to travel to Wivenhoe after my parents told me they were very concerned about his behaviour. I spent the weekend with Josh and he was clearly not well and so following this, on 11 May 2020, I sent a text message to [I/S] his CC which stated as follows:

> "*I had to go to Wivenhoe this weekend because Josh has been so unstable. He has been off his meds for weeks, he says this was on the advice of his psychiatrist. This urgently needs to be sorted out since my parents simply cannot cope.*"

48. The next day, 12 May 2020, I received a reply from the CC which stated that he had met with Josh the day before, and that he was now planning to speak with his Consultant Psychiatrist. I replied to this stating that:

> "*I am also keen to speak to the consultant. We are very worried things are deteriorating fast because he has been off his meds for so long. Do you think we could give the consultant the background?*"

49. The CC replied to me the next day, 13 May 2020, stating:

> "*Joshua told me that he is taking his medication however I am not sure about his complaints. I had discussion with his consultant* [sic] *and arranged face to face appointment for Joshua to attend on 21st May. hopefully we can help him get better soon thanks*"

50. My family and I were very anxious to make it clear to the professionals involved in Josh's care how we had repeatedly seen his illness manifest before and his pattern of deterioration, particularly when not taking his medication. We were concerned Josh would deteriorate to having suicidal thoughts again, and there remained no clear or thorough care plan which Josh was entitled to under s.117. I sent a further text message to the CC on 16 May 2020 underlining these concerns:

> "*Hi* CC *– thanks for this. I have just spoken to my parents. We think it is important that the family can feed in our concerns to you and the consultant. We don't think Josh is taking his meds regularly and we are back to the vicious cycle where Josh is insisting on private medical treatments for imaginary illnesses. We need to break this cycle. Could we perhaps speak next week ?*"

51. Following this, an appointment was arranged with Josh and his Consultant Psychiatrist Dr [I/S] on 21 May 2020, which I also attended. Before this meeting, I again raised concerns with his CC in relation to Josh receiving s.117 aftercare, and texted

him to say "*Josh should be on a s.117 care plan and as far as I am aware ian I* [sic] *care plan!*". I meant to write that as far as I was aware, there was no care plan.

52. I arranged to speak with Dr [I/S] by telephone in advance of the meeting with Josh. We spoke on 20 May 2020. During this call I reiterated my concerns for Josh, stating that I was worried he was stuck in a vicious cycle, on and then off his medication, and becoming very ill very quickly. In particular, I asked about the possibility of Josh receiving his antipsychotic medication via injection (a depot), given the repeated problems with non-compliance. I asked again about s.117 aftercare for Josh and explained I was not aware of any steps having been taken to have a plan to prevent Josh deteriorating and needing to be admitted again. Dr [I/S] told me that someone, possibly **the CC**, would look into s.117 and get back to me.

53. On 21 May 2020, I attended the meeting with Dr [I/S], [I/S] (Locum Consultant Psychiatrist) and Josh. To my concern, the consensus of the clinicians appeared to be that Josh was only presenting with signs of anxiety at that stage, not psychosis. The corresponding record of this meeting notes that Josh himself spoke about having felt better after re-starting the Aripiprazole, before he stopped taking it. He repeated his familiar beliefs about having a genetic disorder and needing to have physical testing. I raised again the possibility of starting Josh on depot medication. This did not however appear to be given any, or any proper, consideration by those at the meeting. The recorded plan from this meeting was simply that Josh's Sertraline would be increased to 100mg, and he would be seen for a follow-up review in several months' time.

54. Following the meeting I was provided with a copy of Josh's updated care plan dated 26 May 2020. This care plan described some of the concerning behaviours I and my family had witnessed in regards to Josh at the time, including Josh questioning how his antipsychotic medication was helping him (which was his motivation to stop taking it), and further that:

> "*His main concerns currently are: "never learned to drive", "social skills decreasing", "have being on a mission to find what is wrong with him", has a "neurological deficiency", "my eye tracking is not normal", "when walking, bumping into people", "when mind is occupied, I have difficulties talking", "my voice sounds high-pitched". He said his condition was not taken seriously by his GP when all tests came back negative.*"

55. These are all examples of how me and my family understood Josh to exhibit his psychotic symptoms. The care plan further described how Josh:

> "*said that he "needs in depth physical testing" and "he reached the point, that he can't get help on a local level". His physical health concerns are leading him to the "dark place in his mind", he "reached a dead end", he "tried every avenue – nothing worked'*"".

56. I was very disappointed with Josh's "care plan". I felt that it lacked a proper understanding or even attempt to understand the triggers for Josh's non-compliance with his medication and the risks this posed. The care plan did not even acknowledge that what was stated as Josh's "main concerns" (as in paragraph 54) were in fact familiar psychotic symptoms for Josh – for instance, the focus on another illness to explain his problems. Further, I was very keen for Josh to be receiving holistic, multi-agency input, and for attempts to be made to get him out of his flat and into positive activity, none of which was mentioned on the care plan. I felt that no meaningful measures or safeguards were identified in this care plan, or arising from this meeting, as to how to prevent Josh's deterioration to a point of crisis, where he would require inpatient admission again.

Summer 2020

57. Josh remained mainly off his antipsychotic medication throughout the summer, and his behaviour continued to be very unstable, with increasing paranoia, delusional thoughts and erratic behaviour. He also started to repeatedly express suicidal intent.

58. In late June 2020, there was an incident where Josh became very argumentative and shouted at various family members. Following an incident where Josh said to our mother "love you mum and goodbye", we again became very concerned for his safety and raised concerns with his care coordinator [I/S]. My mother explained to the CC that we did not feel that Josh was safe to be in the community. I spoke with the CC shortly after this and explained that I also believed Josh needed a period of admission as he was so unstable and talking about ending his life.

59. Due to his unstable behaviour, Josh's flatmate [I/S] also told him that he wanted him to move out. I have since seen an entry in the EPUT records, dated 30 June 2020, which refers to Josh's CC speaking to Josh's flatmate, who reported that Josh had stopped taking his medication six months before, was acting paranoid, shouting 'danger' and running around the house. The risk of Josh losing his accommodation inevitably added to his distress, and the stress we all faced in trying to support him. Josh would sometimes stay with our parents in their 'annex' (a separate part of the home which pre-COVID they would rent out), however he was too unstable to be living so close to our parents long-term. He continued to live with his flatmate until the latter end of 2020, however the situation became increasingly difficult.

60. On 6 July 2020, I sent a text message to Josh's CC stating that:

> "*I have just been to Wivenhoe to see Josh and my parents. I know my parents are speaking to you. Josh is in a bad way and it feels like things could blow up any minute. Can we please find a time to speak as soon as possible?*".

61. This was prompted by Josh becoming increasingly aggressive, which led to my parents locking the doors to their house out of fear for their safety. It was clear to me and my family that Josh was not taking his medication, though he was claiming he was.

62. In July 2020, I went on holiday with my family and Josh's son to Dorset for a week, and we arranged for Josh to join us. However, Josh refused to come. It was also around this time that Josh first began to talk about potentially asking a family friend named Professor Mark Solms for assistance. Professor Solms is a Professor of Neuropsychology at the University of Cape Town and the partner of a family friend.

63. In late July 2020, I received a copy of an updated care plan for Josh dated 17 July 2020, which followed a review meeting by Dr **[I/S]** with Josh on 15 July 2020. I did not attend the meeting on 15 July 2020, and I do not recall being invited or told about it in advance, despite the repeated concerns we as a family were raising with the Specialist Psychosis Team in this period and despite the fact that Josh had made it clear that he consented to and wanted his family to take part in meetings with professionals. I was, again, very disappointed with Josh's care plan, which I did not believe to be remotely appropriate for Josh's needs. It did not match my understanding of a what Josh was entitled to as part of s.117 aftercare. The care plan made reference to Josh believing he had PTSD. This was a growing focus for Josh, who was increasingly looking for an alternative to psychosis as a source for his problems, and as a justification for coming off antipsychotic medication. It was frustrating to note that the care plan, and seemingly Josh's psychiatrist, failed to recognise that this was in fact a symptom of Josh's psychosis, where Josh would constantly reject his presentation of psychotic symptoms and search for an alternative diagnosis and treatment. There was also no discussion in the care plan of Josh being prescribed long-lasting depot injections of antipsychotic medication, despite his known history of poor compliance and my expressly raising this as a potential option to help keep Josh stable.

64. In August 2020, I spent two weeks staying with a friend in Wivenhoe with my wife and daughter and Josh's son. I saw a lot of my parents during these two weeks, but Josh did not want to spend much time with me or his son, and I saw little of him. Josh seemed to be increasingly turning in on himself, and was finding it difficult to interact with others, even his family. Part of Josh's paranoia was that he felt rejected by his own son which really upset him and meant he refused to spend time with him. There was an incident while I was staying in Wivenhoe when we did see Josh, where he became very angry and upset as he felt that his son and my daughter (who were both around 7 years old) were ganging up on him.

65. Also around this time, Josh's focus shifted to 'Camphill' (a community for people with learning difficulties) as a place where he wanted to go to volunteer, where he thought things would be better for him. Josh explained that this was a kind of residential community, in the UK and America, and he wanted to go to a volunteer placement in upstate New York. Josh explained to us that he wanted to stop taking his medication, and instead wanted to get fit. He was regularly jogging and bought a weighted top which he exercised in. Josh viewed the Camphill placement and exercise as a form of 'treatment' which he hoped would solve his problems and meant he did not need mental health care or medication.

66. I met with Professor Solms for the first time in August 2020. I believe Josh and my parents may have had some interaction with Professor Solms prior to this, but this was the first time I had met him. I believed that Professor Solms may have been able to offer some informal assistance to Josh, due to his professional background in the mental health field. Professor Solms very kindly did offer some assistance to us. He was very generous with his time for Josh and our family and we met (virtually, as Professor Solms lives in South Africa) on several occasions as described below.

67. When we first met with Professor Solms in August 2020, he listened to Josh's concerns and tried to give him some encouragement and something he could look forward to. I was keen that Josh understand that he could do exciting things with his life if he got the treatment he needed, and Professor Solms tried to help convince Josh of the same.

68. On 20 August 2020, I sent a text to Josh explaining that our parents (who were in their late 70s) could not be involved in his care anymore. I wanted to stop the repeated aggression Josh directed at our parents when he was unstable. I was taking the lead in respect of being a point of contact between Josh and professionals involved in his care in the hope I could help him get the care he needed and relieve some of the stress on my parents.

September 2020

69. In a statement from **Josh's CC** provided in the inquest, there is reference to Josh going to Wales for two weeks for massage therapy in early September 2020. This was exactly the type of thing that Josh would do believing this would 'fix him'.

70. By mid-September 2020, Josh was really spiralling out of control. On 14 September 2020, I sent a text to **the CC** stating (about Josh):

> "*He is very unwell again and in need or* [sic] *urgent psychiatric attention. His treatment plan is not working. Please call me urgently ! Thank you. Dan*"

71. This contact with **CC** was prompted by a marked further decline in Josh's condition and his continued refusal to take his medication. My mother had contacted the Crisis Team on 11 September 2020 to raise her concerns who, it appears from the records, then spoke with Josh before referring him back to the Specialist Psychosis Team. By this stage, Josh was speaking obsessively about needing to flee and how he was 'unsafe' in Wivenhoe. He also continued to obsess over imaginary illnesses that he self-diagnosed. For example, in late August 2020, Josh texted me with a link to a DNA test, explaining he felt he had some kind of genetic disorder and how he was "desperate to find an answer". I felt that it was important for Josh to be reviewed by his community psychiatrist as it was clear that he would, without urgent intervention, continue to decline to a point of crisis.

72. **Josh's CC** responded to me by text message on 15 September 2020 stating:

> "*...I spoke to him* [Josh] *yesterday and arranged to see him on next week* [sic]. *He does not want to take his medication I will discuss with dr soon and let you know.*"

73. I replied to this text the same day, emphasising that Josh was "*in a bad way*", that "[*h*]*e is not well at all !*", and asking for a meeting with the family and Josh's psychiatrist so that we could share our concerns. **The CC** responded by indicating that he would try to arrange an appointment for early the next week.

74. At this time, Josh and I were meeting with Professor Solms on a regular basis, and I was keen to keep this up alongside trying to arrange meetings with and input from professionals in the EPUT mental health services. I did not want to challenge Josh about his concerns of having a genetic disorder, as I did not think he would respond well to this. Instead I hoped that Professor Solms may be able to speak with Josh about his concerns, and that Josh may respond better to someone with a professional background in mental health. My main focus at this time was for Josh to be supported to regularly and consistently take his antipsychotic medication and stabilise. A view within our family was hardening that Josh needed to be put on antipsychotic depot injections due to repeated problems of non-compliance. I had first heard of antipsychotic depot injections as a potential option for Josh while he was an inpatient at the Highgate Mental Health Centre. Depot injections were not ever raised as an option by professionals from EPUT, although, as noted in the contemporaneous records, I had asked if they were a possibility. In particular I wanted this to be looked at as part of the s.117 aftercare for Josh, which remained, to my knowledge, non-existent. I understood that depot injections could be administered once every three months, which my family and I increasingly felt could be a good option to help Josh's condition improve.

75. Following my communication with **Josh's CC** in mid-September, I understand that he went to visit Josh on 17 September 2020. I note from the records that, during **his** visit with Josh that day, Josh was presenting with paranoid behaviour about strangers not liking him, his family not understanding him, and needing to move out of Essex, as well as reporting the sudden onset of medical problems in respect of which there was no physical evidence. I sent a text message to **CC** in the afternoon which informed him of my concern that:

> "*Josh is not good at all today. He need(s) to take medication and it won't be available for 2 days. Can you possibly get him an urgent prescription? He is close to needing to go to hospital I fear.*"

76. I received a telephone call from **CC** later that day. **He** explained to me that, despite our request to urgently meet with Josh's psychiatrist, an appointment would not be available until the end of October (over a month away). I explained to **CC** that we could not wait until the end of October and that Josh needed more support urgently. This unfortunately was in line with a pattern of interactions I had with **CC** who would always be very sympathetic and would listen to my and the family's concerns, however very little would appear to happen as a result. I have since had sight of records which indicate

that, following CC's visit to Josh on 17 September 2020, he rated Josh as risk assessment level 'green'. I was very surprised to see this assessment, which does not remotely reflect my view of how Josh was around this time; he appeared to me and the family to be in a worsening state of crisis and on the verge of needing a period of admission to hospital.

77. On 22 September 2020. I sent a further text message to Josh's CC in which I chased a meeting with Josh's psychiatrist, as well as any volunteering options to help get Josh active. I explained that while "*Josh is a little better*", which was fairly typical of Josh's instability, "*we urgently need to have a family meeting* [with Josh's psychiatrist]".

78. Throughout this time, Josh was still living [I/S] with a flatmate. However, as described above, things had fallen apart with his flatmate which was very stressful for Josh. He was keen to find alternative accommodation, and he also remained fixated on going to Camphill in America. Josh would sometimes stay with our parents in their 'annex' (a separate part of the home which pre-COVID they would rent out), however Josh was too unstable to be living so close to our parents. Josh also continued to search for and send me links to alternative therapies he hoped would help him, such as forms of 'molecular psychiatry', or DNA therapy. Josh spoke of not feeling 'peaceful' in Essex, that he felt people were targeting him and that he found being in nature helpful so he wanted to move to a rural area (despite Wivenhoe being a rural area).

October 2020: Referral to the Home First Team

79. Josh remained very unwell in early October 2020. On 7 October 2020, I sent a text message to Josh's CC asking for an update in respect of a (EPUT) support worker for Josh, who I understood would be able to help him with practical issues, for example, find new accommodation and some activities or volunteering. My main focus remained getting Josh back on antipsychotic medication and active in some way. Josh was spending his time sitting at home, where he had by then fallen out irreparably with his flatmate, looking up mysterious illnesses and cures online, and researching far-flung places, often with the promise of a cure or solution, he could 'flee' to. In my text to the CC I stated:

> "*Is there any news about the new support worker for Josh? He needs help to get into some activity and his accommodation is likely to come to an end soon so he is going to need help to be rehoused.*"

80. His CC replied to me later that day, from which it was clear that Josh had also been telling CC that he needed to 'flee' Essex, as CC said "*he* [Josh] *wants to move to Suffolk or somewhere not in Essex. I am not sure where he wants to move*". This was typical when Josh was unwell, and was part of the pattern of symptoms we had seen before: desperately searching for an alternative solution to his problems, and a paranoid obsession that those around him (in Essex) were hostile toward him. As above, by this point Josh was frequently refusing to engage with the family and our efforts to get him to take his medication and occupied productively. I replied to CC on 7 October 2020, stating:

> "*Hi* **[I/S]** *– Josh is all over the place and can't navigate anything without a support worker. Can I have the contact details of the new support worker please? Thanks Dan.*"
>
> *He does not accept advice or help from the family – so we are entirely reliant on support workers. We are happy to look into paying for private support but we don't know where to turn to.*"

81. I note from the records that **CC** visited Josh again on 8 October 2020. In the corresponding record of this assessment, **CC** noted that he did not consider that Josh was presenting with any psychotic symptoms, appearing instead "*fixated with his family and others surrounding him".* This was in the context of Josh reporting that those around him did not care about him, did not want to listen to or hear anything from him, and did not treat him as 'disabled' when he was. These types of statements were in fact entirely consistent with Josh's psychotic presentation, as my family and I had repeatedly attempted to explain to the EPUT mental health services.

82. My family and I believed the situation with Josh was becoming desperate and that he urgently needed to stabilise and receive intensive support. I sent a further text message to **Josh's CC** on 9 October 2020 chasing an update:

> "**CC** *– any news. Josh is in perpetual crisis and we at a complete loss. He needs more proactive help. Please respond. Thanks!*"

83. For the next few days Josh remained in a crisis and appeared to be deteriorating. I was in text contact with Josh at the time, who sent me messages saying that all he wanted was a safe place to live and decent medical care. Josh told me that he was being 'thrown out' of his accommodation with no support following a falling out with his flatmate; he described his living situation as unsustainable. He said he had nowhere to feel safe and that he was emotionally hurt. Josh asked me to help him find an Airbnb to move to, and to pay for it, and he sent me links to properties in Wales. Josh seemed to be spiralling further out of control. I sent a further text message to **CC** on 13 October 2020 stating:

> **CC** *please call me. Josh is saying he is unsafe and afraid. We really need urgent help.*"

84. **CC** telephoned me later that day. I again emphasised my concern that Josh needed a support worker, and that Josh would be left without any support if he moved out of Essex, which he was apparently planning to do. **CC** told me that he would follow up about a support worker and local activities for Josh, and come back to me. Despite my persistent attempts to get in place a s.117 package (from the time Josh moved back to Essex) and a support worker, and reassurances from **CC** that this was being pursued, nothing was put in place.

85. Around this time, in early October 2020, I met with Josh in person in our parents' annex, where he was staying temporarily. During this meeting Josh clearly expressed thoughts and plans to end his life. He told me that he did not want to 'make a mess', but wanted to end his life. I told him not to be ridiculous, and that we would get him through his current crisis and stable again. I remember telling my wife afterwards that I took this seriously because although Josh had made such threats before, he had always seemingly done so in order to get something from me or his parents. This time he was not using the threat as leverage and was already trying to distance himself and disengage from us.

86. On around 14 October, Josh left his flat and Essex, and went to Wales. Following this, he ended up in Reading. Professor Solms forwarded me an email Josh had sent him on 14 October 2020, in which Josh said he was "*...in reading, homeless. Not sure what's going on*". Josh was desperate to get away from Wivenhoe, in particular because of the situation with his flatmate. I said to Josh that his flatmate could not kick him out, and that we needed a well organised plan to resolve Josh's living situation. It was also around this time that Josh's efforts to be accepted by the Camphill placement in America suffered a setback, which really upset him. Josh spoke with one of the managers at Camphill, while in a state of distress in Reading, and during the call Josh's illness clearly became apparent to the manager. Josh believed this had ended his chances of being accepted on the placement. Josh had been fixated for several weeks on the volunteer community as the 'treatment' he needed and his only hope.

87. After a few days, Josh then returned to Essex and moved into our parent's annex. Shortly after he returned, on 18 October 2020, there was an incident where Josh spoke to our mother about a specific plan to end his life. He went to get a rope from the garden shed and the police were called. This followed his repeated expression of suicidal thoughts over the previous day or so to my mother. I understand that the ambulance service and later the police attended and removed the rope. The Crisis Team were also contacted, who spoke with Josh and then updated the Specialist Psychosis Team. I was not present during this incident, as I was back in London, however I was immediately informed of it by my parents.

88. Following this incident I was certain that Josh's life was at risk and that he urgently needed significant psychiatric intervention. I wanted to know who we could contact at EPUT to request this. On 19 October 2020, I sent a text message to **Josh's CC** to ask who we could contact:

> "*Hi* **[I/S]** *- another very tough weekend with Josh, who has been travelling around the country in a state of confusion and threatened to commit suicide on Sunday. The police were called and he remains very unstable. The crisis team were alerted. We really need enhanced intervention in his case urgently. Who do I contact in the Trust to make my case? We need to act before its too late. Thank you.*"

89. The CC informed me later that day that he had referred Josh to the Home First Team "*to assess [him] whether he need a hospital admission*". From the EPUT records I have since reviewed, I can see this followed CC visiting Josh that day, on 19 October 2020, during which Josh was noted to present with worsening paranoid ideation and stated there was no point in living. I note in particular that, when CC raised the prospect of potential hospital admission, if Josh continued to refuse his treatment plan, Josh is recorded to have said he was willing to go to hospital if needed. It appears that, following this visit, CC spoke with one of the team's consultant psychiatrists, Dr [I/S] about a referral to the Home First Team for a gatekeeping assessment.

90. I understood that, following this referral, Josh would be placed in the care of the Home First Team, which meant the CC would be taking a step back from Josh's care until they discharged him. However, as I did not immediately receive any contact from the Home First Team, I sent a further text to CC on 20 October 2020, explaining: "*We are not clear what the plan is for Josh. We think he needs a spell in hospital.*" I also asked CC who we could contact to raise these concerns.

91. Unfortunately, my and the family's experience with the Home First Team was one of deep frustration and an almost total lack of communication. Despite the fact that Josh had given consent for the family to be contacted and consulted on an ongoing basis, they made no attempt to contact us, or invite us to contact them, in order to understand the background to Josh's illness and current crisis. They dealt directly with Josh, who was very erratic and confused at the time, and did not inform us of their meetings with him.

92. I now understand that Josh first met with the Home First Team Consultant Psychiatrist, Dr [I/S] via video call on 20 October 2020. Neither I nor my parents were informed of or invited to this meeting, and I did not therefore attend. I have since had sight of the clinical entry concerning this meeting which suggest that Josh asked to be taken off his antipsychotic medication during this meeting, and that he reported his main problem to be that he was suffering from an undiagnosed autistic spectrum disorder, in addition to schizoaffective disorder or PTSD. I was very concerned to read that Dr [I/S]'s impression of Josh during this initial meeting was that he did not have overt psychotic symptoms, and that Josh was likely presenting with an 'Acute Stress Reaction'. If I or Josh's family had attended this meeting or been consulted, we could have explained that Josh believing he suffered from an undiagnosed illness and a desire to flee were familiar psychotic symptoms whenever Josh was not on his medication.

93. For the next week Josh continued under the care of the Home First Team. During this period, Josh remained very unstable and communicated further thoughts of ending his life to my mother, which she reported to CC While I understood that members of the Home First Team were visiting Josh, they did not make any contact with me or the family and gave no way for us to contact them. In the end my mother Florence had to track down a member of the Home First Team when they were visiting Josh, and we eventually got a telephone number for the team. However, when I did eventually speak with the Home First Team, communication from the different professionals involved in

Josh's care was seemingly contradictory. Josh's CC had told us that the Home First Team would now be taking the lead on Josh's care, however the Home First Team told us that we should speak to CC and the Specialist Psychosis Team, about arranging increased support for Josh. I spoke with a member of the Home First Team [I/S] and tried to explain our concerns about Josh, the relapsing pattern his illness would take and why he should be considered for admission to hospital. Unfortunately, in all of my contacts with the Home First Team I consistently felt that my engagement and involvement in Josh's care was unwelcome and they had no real interest in what we as a family had to say.

94. From review of the medical records, I can see that, during a visit by the Home First Team on 24 October 2020, Josh was noted to present as "*quite manic/psychotic",* speaking about Karma and people who had wronged him. The same record also refers to my mother informing the team of an incident the night before, where the police were called after Josh disappeared stating he was going to the train station to end his life. I do not recall being made aware of this episode at the time, though it is consistent with Josh's general decline and worsening suicidal ideation in this period. There appears to have been a further home visit on 25 October 2020, where Josh was observed to be in significant distress, saying that he needed someone stronger than him to kill him. The Home First Team practitioner cut short the meeting due to concerns for his own safety. In both of these contacts, Josh is recorded as having raised the option of hospital admission himself, indicating he would accept this if offered. His 'RAG' rating by this stage was 'red'.

95. On 27 October 2020, I spoke with [I/S] of the Home First Team. I explained my continued serious concerns about Josh, that he remained unstable, would frequently not make sense and threatened suicide. I recall this being a very difficult conversation. I was angry and expressed my displeasure at the way the Home First Team were dealing with Josh and the family, who were still not being consulted or even informed about his treatment. We were very concerned that the Home First Team were shutting us out, despite our long history of involvement in Josh's care and treatment, and that they lacked basic information and understanding about the nature of Josh's illness and risks.

96. It was around this time, in late October 2020, that we were due to attend the long-standing appointment which had been arranged for 29 October 2020 with Josh's consultant psychiatrist (which we had been waiting for over a month) in the Specialist Psychosis Team. This was however cancelled without warning the evening before. I spoke with Josh's CC about this, who informed me that this was because Josh was now under the Home First Team. The appointment had been arranged in part to explore long-lasting depot injections of antipsychotic medication to help stabilise Josh. I was very angry that is had been cancelled; we had been waiting for the appointment for a month and I had hoped it would be a real opportunity to get Josh back onto his medication and to put a longer term plan in place for Josh. I had travelled to Wivenhoe from London especially for this meeting, only to be told at the night before that it was cancelled..

97. Instead of the planned review by the Specialist Psychosis Team psychiatrist, a meeting was arranged with Dr [I/S] from the Home First Team for 30 October 2020. I found out about this meeting through Josh, but had already travelled back home to London and so attended remotely. As I recall Josh also attended remotely, however I understand from my legal representatives that there is no entry in the clinical notes for this appointment. In this meeting I explained to Dr [I/S] that Josh was not taking his antipsychotic medication and that this needed to be resolved as a priority. Josh by contrast said that he wanted to try an anti-anxiety medication as he reported feeling very anxious. I explained to Dr [I/S] that an anti-anxiety medication would not help Josh as he was psychotic, displaying characteristic symptoms with which we were all too familiar. I explained that Josh would become much more unwell when not taking anti-psychotic medication, and that he had subsequently developed a generalised sense of persecution, believing everyone in Wivenhoe to be against him. By this stage Josh appeared to have homed in on anxiety as a new self-diagnosed condition which he contended was the real source of his problems. He stated that people in Wivenhoe had picked up on his anxiety which was why they did not like him.

98. Unfortunately, it seemed that Dr [I/S] had not familiarised himself with Josh's notes and was not aware of his vicious circle of behaviour that this was a part of. As such – despite my express attempts to explain the situation to him - he did not find Josh to be overtly psychotic. As a result, to my complete dismay Dr [I/S] decided to take Josh off antipsychotic medication and to instead try him on a period on an anti-anxiety medication (Pregabalin). The meeting was around 30 minutes long. It felt rushed and the Doctor did not seem to understand the complex background to Josh's case. I was very concerned by the change in his medication plan, but the Doctor said that we should try this and, if it was not working after a few days, we could change tact.

Early November 2020: Discharge from the Home First Team

99. Following this change in medication, Josh said he immediately felt a lot better, which was typical for him when trying a new treatment he wanted. Unfortunately, it was clear to the family, very shortly afterwards, that the new medication was not working and things were unravelling again. Within two or three days, Josh was once again expressing general paranoia, the desire to flee, and saying that he was not mentally ill but suffering from an undiagnosed physical illness.

100. I have had sight of the medical records from this period which note that the Home First Team, who Josh was still open to, repeatedly found him during home visits to be "*settled*" and did not report any significant concerns about his presentation. This contrasts dramatically with my any my family's own interactions with Josh around this time, who seemed very unwell. If I had been contacted by the Home First Team, I would have made this clear. During this period, it was common for Josh to initially come across as coherent when meeting him. However, if you asked him specific questions to test his presentation, his psychosis would become quickly apparent. For example, if you asked Josh how do you feel about the people of Wivenhoe? How do you feel about your health? Do you feel safe? Unfortunately, despite considerable efforts, I had not had the opportunity to fully explain to the Home First Team that this was required to understand

Josh's illness, and the few times I was able to get through to someone at the Home First team my overwhelming sense is that they felt I was a nuisance and were just trying to end the conversation as soon as possible.

101. Josh sent me a lot of text messages in early November 2020, in which he repeated familiar themes of concern about having some kind of inherent psychological difficulty which meant he could not function in society, that medicine could not help him, and that he had this issue since he was 16 years old. Josh was also frequently talking of suicide by this point, and in particular spoke with my mother about his wish to die peacefully.

102. On 11 November 2020, I spoke by telephone with **[I/S]** of the Home First Team. I explained that Josh had clearly deteriorated since coming off antipsychotic medication, and that he needed an urgent medication review by a psychiatrist. I explained that Josh had increased paranoid thoughts and spoke more frequently of suicide. I was informed that there would be a 'joint visit' (with the Home First Team and **the CC**) to Josh the next day. I was not informed that – as it later turned out to be – this would be a discharge meeting from the Home First Team. If I had been, I would have jumped in the car and come down to attend in person to ensure that the Home First team fully understood the very serious situation we were in.

103. On 12 November 2020, it became apparent, I believe after Josh contacted me, that the joint meeting would be a discharge meeting with **Home First** and **the CC** where Josh would be transferred back to the care of the Specialist Psychosis Team. I attended at short notice by telephone. I made it clear on the call that the family considered Josh was a serious suicide risk and that he urgently needed a medical review so he could be placed back on to antipsychotic medication. We felt that the change in medication in late October 2020 by the last psychiatrist had been a disaster, and I had been very worried for several weeks now that Josh's life was at risk. I also raised concerns that, as Josh was being discharged from the Home First Team and his last consultation with the Specialist Psychosis Team had been cancelled, he would fall between the cracks at a critical time and that it could take weeks to arrange another consultation. I was reassured that this would not be the case. It did not seem to me that Josh was engaging with this meeting at all. I have since had sight of relevant clinical entries which indicate that, following this meeting, Josh's 'RAG' risk level was rated as 'green' by professionals in Josh's care, despite having been rated as 'red' only three weeks before. I was very angry and disappointed to see this assessment, given all the concerns I had raised at the meeting and over the past several months. I can only conclude the concerns I raised were ignored or dismissed.

104. On 14 November 2020, I arranged with my parents and Josh to speak with Professor Solms. I and Josh had remained in regular contact with Professor Solms. Josh's willingness to engage with Professor Solms would fluctuate, and on a number of occasions he agreed to a particular treatment plan, such as psychotherapy, only to later find an alternative therapy which he was more interested in and felt was a quick-fix solution for his problems. By this point, I felt that Professor Solms had a good understanding of Josh and the way he presented when unwell, and I hoped he may be able to offer some advice given the frustrations we were experiencing with EPUT

professionals and the failure to engage with the repeated concerns the family was raising. I was particularly concerned given that Josh still appeared to be deteriorating, but would now be visited less frequently by professionals given he was no longer under the care of the Home First Team. In this meeting Professor Solms took the time to ask Josh some searching questions and saw how irrationally Josh was behaving. I recall at one point during this meeting Josh stating that, in addition to his intense feeling of persecution, he felt like he was walking around without a spine and without a centre of gravity. Professor Solms was alarmed by how he was speaking, and agreed that Josh needed to be placed on to antipsychotic medication immediately. Professor Solms talked this through with Josh, who also now agreed he should go back on to antipsychotic medication and also that he would try this in depot injection form. Professor Solms agreed to write a letter which could be shared with the EPUT professionals which set out his and Josh's view.

105. Later on 14 November 2020, I sent a text to **Josh's CC** stating:

> "*Hi* **[I/S]** *– we have consulted Prof Mark Solms, a leading neuropsychologist. His view is that Josh urgently needs to be put back onto an anti-psychotic, preferably by injection. Josh is willing to consent to this. Would it be possible to get an appointment next week ? This is really urgent...Ps Prof Solms will be sending a letter setting out why he thinks Josh needs to be put on an antipsychotic.*"

106. On 15 November 2020, I forwarded a copy of the letter from Professor Solms to **[I/S]** **the CC** by text, and asked for a response as soon as possible. This letter set out how Josh had significantly deteriorated since his last meeting with Professor Solms, which was, in Professor Solms' view, likely as a result of the withdrawal of antipsychotic medication. Professor Solms also explained how Josh's "*current presentation is clearly psychotic*", and listed by way of illustration various behaviours that the family had come to recognise as familiar manifestations of Josh's psychosis (namely paranoia, persecutory thoughts, and a fixation with undiagnosed conditions), stating:

> "*He is paranoid (believes that everyone hates him and that the townsfolk are observing him with derision), he complains of odd bodily sensations and is hypochondriacal to the point of somatoparaphrenia (e.g., loss of the sense of gravity, a feeling that his spine is hollowed out) and he has a fixed belief that he suffers from an undiagnosed chromosomal disorder despite all the medical evidence to the contrary*".

107. Professor Solms went on to explain in this letter how Josh had himself agreed to be put back on to antipsychotic medication, and further that he had agreed to try this in depot injection form given his previous problems of non-compliance.

108. **Josh's CC** replied to me the next day, 16 November 2020, stating that he had forwarded Professor Solms' letter to Josh's psychiatrist (i.e. within the Specialist

Psychosis Team). I replied, again emphasising that Josh needed an urgent appointment, and that "*I can't believe he had been left hanging like this when he is clearly psychotic !*". Over the next few days I continued to chase CC for an update in respect of a meeting with Josh's psychiatrist, and repeating my concern that Josh was increasingly delusional and recognised himself the need to be back on an antipsychotic as soon as possible.

109. I now understand that, on 19 November 2020, Josh was contacted by Dr [I/S] [I/S] (one of the consultant psychiatrists within the Specialist Psychosis Team) for a phone consultation. However, despite my numerous requests to CC to be included in the meeting, I was not invited. CC informed me, in response to one of my messages asking to join, that it was only a *"quick call*", not a full appointment. I have also since seen in the records that my mother messaged CC as well, asking if she could attend the meeting, as there was "*continuous chaos around (Josh's) case",* to which it does not appear she received a response prior to the meeting. Neither of us therefore attended the meeting. I have since had sight of the clinical entry concerning this call with Dr [I/S] in which it is recorded that Josh denied having any psychotic symptoms or needing antipsychotic medication. No new prescription of antipsychotic medication was given to Josh, who instead was provided with some information leaflets on various antipsychotic medication. Josh later reported to me that they had discussed in this meeting the possibility of depot injections as a way of taking anti-psychotics (which, as above, he had already agreed to trialling in his meeting with Professor Solms). Despite this, no changes to his medication regime were made – Josh was simply referred back to his GP for consideration of an increase in his anti-anxiety medication. I was extremely disappointed by the apparent lack of urgency or understanding of Josh's condition by Dr [I/S] in this meeting. I had seen a pattern play out previously where, when Josh was as unstable and erratic as this, he would not offer the whole story to his doctors, particularly in brief consultations. It was for this reason I was so anxious to be present during any contact between Josh and his psychiatrist, so that I could ensure that Josh properly engaged with the meeting, and the psychiatrist was able to understand the extent of his psychotic symptoms and the urgency of the situation.

Late November 2020

110. Josh continued to be very unstable and unwell following his phone consultation with Dr [I/S] On Saturday 21 November 2020, Josh went to our parents' house and again threatened suicide. This resulted in an ambulance and the police being called, and I contacted the Crisis Team by telephone. On this call I expressed my anger at how Josh's discharge from the Home First Team had been handled. I understand Josh's medical notes record that we told the Crisis Team that Josh had said that he was able to buy medication online which he wanted the family to help him use to kill himself. Neither my mother nor I recall this being communicated to us by the Crisis Team, however by then Josh was regularly saying he was going to end his life by different means. We as a family had reached a point of real desperation by this stage. We felt we had tried every means possible of protecting Josh and getting him the help he urgently needed from the EPUT mental health services, however, with no one having heard or

responded to our concerns, we were now witnessing Josh spiralling into an acute crisis before our eyes.

22 November 2020: the EPUT Assessments for Potential Inpatient Admission

111. The next morning, on 22 November 2020, our mother took Josh to the Abberton Unit, at The Lakes Mental Health Hospital. We felt that the situation with Josh was so serious that he needed an immediate assessment and we were getting nowhere with his community care team. I also now understand, from having reviewed the medical records, that my mother had called the Crisis team that morning as she had been told the service would contact her to 're-triage' Josh following the events the night before, but this had not happened. My mother spoke with Community Psychiatric Nurse ('CPN') [I/S] to whom she reiterated her concerns for Josh's safety and his need to be reviewed urgently. The records indicate that CPN [I/S] then spoke with Josh on the phone, to whom he reiterated his intention to end his life *"by any means".* As a result of this, I understand that CPN [I/S] advised that my mother bring Josh in for an urgent 'risk review' at The Lakes that day.

112. I was in London at the time and so could not attend the review in person, but I tried to participate as best I could remotely. Josh and my mother had to wait for a long time to be seen at the hospital, and in the end I had to walk the dog. While I was out with the dog my mother telephoned me as the consultation had started and so I attended via speaker-phone while I was still walking with the dog. My father also joined the assessment by phone.

113. This first assessment was with CPN [I/S] who, as above, I now understand was part of EPUT's Crisis Team. At the start of the consultation, I heard a very careful history being taken from Josh and our mother Florence by the nurse. It was very reassuring, because she took the time to ask searching questions and to listen carefully to Josh's answers. Josh explained that he wanted to end his life, his concerns around having an undiagnosed genetic condition, and that he felt his son did not like him. I did not say much during this part of the consultation, and was mainly listening to the dialogue between the nurse, Josh and our mother. I found CPN [I/S] very impressive, and Josh opened up to her in a way he did not always with other professionals, such as in the Home First Team. It appeared to me to be a productive discussion and a clear example of the insight that professional curiosity can yield.

114. Following this conversation with all of us, CPN [I/S] asked to speak with Josh alone. I stayed on the phone with my mother while this happened. When Josh and CPN [I/S] returned, it seemed apparent that Josh had made a disclosure or said something in private which led her to believe that Josh was at immediate risk. I have since seen, from the records, that Josh disclosed to CPN [I/S] that he felt "*imminently suicidal",* reporting a "*fixation"* with ending his life by taking an overdose of malaria tablets which, if he had access to at that point, he would have taken immediately. CPN [I/S] also observed that, in this 1:1 with Josh, he denied having any protective factors and was unwilling to return to the family home. CPN [I/S] consequently told us that she felt he should be admitted to hospital. Josh replied saying that he was willing to be admitted. I

said to the nurse that I and the family thought admission was a very good idea. I felt that admission would give Josh the best opportunity possible to stabilise and become compliant on antipsychotic medication again.

115. Having formed the view that Josh needed to be admitted, CPN [I/S] subsequently referred him to the Home First Team for a 'gatekeeping assessment'. I have only learnt of this term retrospectively, through the inquest process. At the time, we were simply told that Josh was going to be seen by another mental health professional to consider his potential admission.

116. I set out below what CPN [I/S] recorded, in the contemporaneous clinical records, by way of her 'recommendation', which prompted a gatekeeping assessment, and with which we as a family firmly agreed:

> "*Josh has continually expressed thoughts, plan and intent to end his life by taking an overdose of malaria medication he intends to buy online. He further insists that he has an absence of protective factors. His family have also vehemently expressed their concerns and anxieties at having to keep Josh safe. I have therefore referred to HFT for a gatekeeping assessment*".

117. The Coroner summarised the evidence CPN [I/S] gave to the inquest into Josh's death about the verbal handover following her assessment that she had with Nurse [I/S] [I/S] from the Home First Team, and that during this handover:

> *"[CPN [I/S] was clear that JL could not be kept safe in the community and required a period of admission as a psychiatric in-patient, something with which the family of JL whole-heartedly agreed and JL himself agreed"*

118. Soon after our meeting with CPN [I/S] we therefore joined another consultation with a member of staff, who I now understand to be [I/S], a nurse from the Home First Team. Both myself and my father also joined remotely for this second assessment; my mother remained present with Josh in person.

119. Nurse [I/S] appeared to take an entirely different approach to CPN [I/S]. Early into the meeting, he stated that - despite CPN [I/S] assessment, the family's and Josh's own agreement to admission as a course of action - Josh did not in fact need to be admitted. He had come to the meeting with a clear view that Josh did not need to be admitted, prior to any further assessment by him. Nurse [I/S] said that Josh needed to be given time for the recently prescribed anti-anxiety medication to work. I tried to explain that Josh was exhibiting serious psychotic symptoms which were very familiar to the family, and that therefore he needed antipsychotic medication. Nurse [I/S] replied stating that *"no psychiatrist in the world would prescribe Josh antipsychotic medication".* At this point I became very angry at this. I told Nurse [I/S] to stop giving his opinions since he was undoing all the work we had done to get Josh to a point whereby he was willing finally to take antipsychotics, if needs be by depot injection. It was clear to me that [I/S] had not properly consulted Josh's records (if at all), despite

later stating in his evidence at the inquest that he was familiar with Josh's history given his previous allocation to the Home First Team. If he had reviewed these notes, he would have seen how hard we had been working, for so long, to get Josh back on to antipsychotic medication, and moreover that a leading neuropsychologist (Professor Solms) agreed that was the best course of action for Josh and written to EPUT urgently to confirm this. Indeed we understood this was also Dr [I/S] plan, as he had previously given Josh some leaflets about different antipsychotic medication, including depot injections.

120. It appeared to us that Nurse [I/S] was overriding CPN [I/S] considered and sensitive assessment of Josh. I have since learnt, from her evidence at the inquest, that CPN [I/S] offered to attend the assessment with Nurse [I/S] however he declined. I do not recall him seeking to explore with Josh in any way, the specific risks and concerns that CPN [I/S] had identified during her assessment. He appeared to make up his mind before he entered the room that Josh didn't need to be admitted or to go on antipsychotic medication. I told the nurse that he was causing great harm with his comments and undermining our efforts to get Josh to comply with his medication. I said that Josh could not leave hospital without antipsychotic medication as he was too unwell. Nurse [I/S] informed us that no psychiatrist was available and therefore no antipsychotic medication could be provided to Josh in any event. He maintained his position that Josh would not be admitted. It was clear to me that he was not willing to listen to my concerns and so I left the call.

121. At the time I believed that the consultation also ended when I left the call, however I now understand from my mother that there was some further discussion. Josh and my mother were given a single telephone number and told to leave the hospital. No discharge or safety plan was provided. They were just told that someone from EPUT would come and see Josh the next day. As well as deciding that Josh did not meet the criteria for inpatient admission, I understand that Nurse [I/S] also concluded that Josh did not require a referral to the Home First Team for more enhanced intervention. As such, Josh was therefore discharged back to the care of the Specialist Psychosis Team and his care coordinator, [I/S] I could not believe that, despite Josh reporting active suicidal ideation, and the consensus from him, our family and a nurse from the Crisis Team that he required inpatient admission, he was just discharged back to the community with no specific plan or support in place.

23-24 November 2020: The Days Leading to Josh's Death

122. Following his assessment at The Lakes, Josh remained very unwell. He was displaying familiar psychotic symptoms and continuing to express suicidal intention. I sent a text message to his CC on 23 November 2020 stating:

> "*Hi* [I/S] *– another very difficult weekend with Josh who was again threatening suicide on Saturday night and was taken to hospital by my mother. He is still not on an antipsychotic despite. Is there any way you can get him an urgent prescription for amisulpride while*

we are waiting for the family meeting with the psychiatrist? In desperation. Dan"

123. I later learned that my mother also sent a text message to CC that day, stating:

> *"Back in contacting you. Sorry* CC *to add to your very long list. We spent many hours on Sunday for yet another assessment. With* [I/S] *the excellent psychiatric nurse. Then we saw* [I/S] *briefly from the Crisis Team. My son Daniel reiterated firmly that Jishua (sic) should be put back on a psychotic medicine alongside the anti-anxiety he is on presently. We just need to keep him alive for the time being as death is a constant on his mind at the moment and the anti anxiety is not fully working for obvious reasons. Can he have both medications without creating the wrong chemistry in his brain? Could it be a mild dose when the other medicine settles step by step? Last point. Joshua was strange, odd tonight making unusual movements with his mouth as he spoke. I did ask him why he was doing that. His response was: 'I am trying not to manipulate' I think he is losing it. Could you write him a prescription? Thank you* CC *for your help. Florence"*

124. Despite being told that someone from EPUT would come and visit Josh on the 23rd, no one came. Since Josh's death, I have learned that when no one turned up, he said to our mother "*you see mum, they did not come*."

24 November 2020

125. On the morning of 24 November 2020, Josh's CC informed us that Josh would finally be assessed by his psychiatrist from the Specialist Psychosis Team, Dr [I/S] the next day. I understood that this would be the meeting that the family had been asking to be held for months, where Josh's medication would be reviewed, and in particular that he may be placed on antipsychotic depot injections. I planned to attend this meeting.

126. I learned through the evidence heard at the inquest that my mother sent a message to the CC that day which said:

> *"I will add that this morning I find Joshua extremely unwell, on the very edge of taking his life. Closer and closer. Though* the nurse *explained it was a matter of patience. Patience is great in principle. On the edge if suicide, it amounts to nothing. He senses that the NHS in its wisdom will do nothing until it is to (sic) late. For this reason he wants to go to the States or to France. A dream. We are utterly stuck and Josh will die. Waking up call. Can anyone help?"*

127. Later that day I received a telephone call from a friend of mine who lived in Wivenhoe to say that Josh had been found dead in his flat by her husband. He had hanged himself.

128. We learned later on that CC had been to see Josh that morning before his death. This visit appears to have been prompted by CC receiving the above message from my mother, and also a text message from Josh himself asking to speak about getting a prescription for an antipsychotic. The medical records indicate that CC called Josh before visiting, during which Josh said he was walking around the woods near where he lived. He is reported to have said he felt suicidal and that he had a plan to hang himself, but would not follow through on it because of his mother. It appears that, during the subsequent visit, CC discussed different antipsychotic medications with Josh, which he was willing to try, and confirmed his meeting the following day with Dr [I/S]

129. We believe that Josh was abjectly failed by EPUT. His deterioration happened in front of us. We knew that Josh had reached crisis point by November 2020, and that this was entirely predictable given:

    a. He was not on the appropriate medication that his illness required, despite attempts over many months to get him back onto anti-psychotic medication and to break the cycle of relapses.
    b. The family were not listened to, repeatedly, by both the Specialist Psychosis Team and the Home First Team (who treated us like a nuisance) and hence important information about Josh's behaviour, risks and history were ignored or missed by EPUT.
    c. Josh was repeatedly seen by different psychiatrists, from across the different EPUT services, which provided no consistency of care or continuity of information-sharing, which was particularly difficult given the sometimes subtle forms of his psychosis symptomatology.
    d. Josh had spent months without any single, comprehensive plan in place for his community care and treatment despite being eligible for a s.117 MHA 1983 care plan. He had no meaningful support to engage in community activities or any other holistic treatment plan. Had a proper plan been formulated from the start this tragedy would have been averted.
    e. Josh was increasingly talking about ending his life. It was clear that Joshua had been spiralling out of control for many months and was not compliant with his medication and clearly needed a period of hospitalisation to stabilise. And yet there was no proper analysis or even broad appreciation of his deterioration over time and no willingness to listen to the family and as a result the seriousness of the situation was missed repeatedly.

130. To leave The Lakes on 22 November 2020 with nothing but a phone number, having had hopes raised of admission for Josh, was the final straw, and, with the background I have described above, was in our view catastrophic for Josh. It was also agonising for us as Josh's family that we had got so close to getting him into a place of safety, where he could get better, only to then feel pulled right back to square one again. We believe Josh's death was totally avoidable and, had his care and treatment been properly planned and delivered, with family involvement and support, Josh would not have died as he did. Indeed, I am firmly of the view that with the right holistic treatment package

Joshua could have learnt to manage his mental illness and would have been able to work and develop a proper relationship with his son.

After Josh's death & EPUT's internal investigation

131. I was informed of Josh's death on the evening of 24 November 2020 by the wife of a friend of mine who lived locally and had gone to ask Josh if he wanted to go for a walk, only to discover he had hanged himself. Essex police then took over and provided us with the paperwork and removed the body that night.

132. We contacted EPUT and were told that there would be an internal investigation. While we were preparing the funeral arrangements, I decided to commit to paper a list of failures by EPUT which had led to his death which I sent on 29 November 2020:

> *We, the Leader Family, write to request a full investigation into the circumstances of Joshua Leader's suicide last week. We are also in touch with the Coroner's Office and have notified them of the concerns we have with respect to Joshua's care by the Essex NHS Foundation Trust, and we are copying them in on this correspondence.*
>
> *We are currently dealing with the shock of Joshua's death, his funeral arrangements and winding up his affairs. Therefore, at this stage, we summarise the concerns we have in short order. In due course, we can provide more comprehensive information and evidence for the Trust and the Coroner to consider as required. The concerns are as follows:*
>
> 1. *Joshua had a history of psychosis dating back 20 years. He had first become known to the Trust as a teenager and had been diagnosed and treated for psychosis for many years. He has a long history of admission to psychiatric hospitals, including the Lakes, including several periods of being sectioned for prolonged periods of time (most recently at the Highgate Mental Health Facility in London in 2019).*
>
> 2. *He had been non-complaint with anti-psychotic medication since June 2020 and had been significantly deteriorating as a result, with increasing paranoia and delusional thoughts, plans and erratic behaviour. He also started repeatedly expressing suicidal intent. From July 2020, we communicated to the Trust that i) we required a family meeting with his psychiatrist to stabilise his medication (and to put him onto depot injections) and ii) that we thought he needed a spell in hospital to stabilise.*
>
> 3. *At the point Joshua took his life, neither of these things had taken place. He was still not on anti-psychotic medication and had been refused admission as an impatient at the Lakes on the Sunday before he killed himself.*
>
> *Home Assessment Team and Failure to provide psychiatric supervision and anti-psychotic Medication*
>
> 4. *In late October 2020 his instability (and expressions of suicidal intent) had become so serious that the Home Assessment Team became involved. Their involvement proved catastrophic. Despite Joshua's consent that the family should be consulted, the Home Assessment Team made no effort to*

consult either with myself or my parents. We consistently had to chase them to find out what was going on since the information we obtained from Joshua was piecemeal and generally inaccurate. During this period, a family meeting with his psychiatrist which we had been waiting for weeks was cancelled, without warning, the night before.

5. *During this period, in early November there was an online consultation with Dr* **[I/S]** *at short notice, who put Joshua on anti-anxiety medication and agreed with Joshua that he should to try a period of time without the anti-psychotic. I attended the meeting remotely. I thought during the meeting. Within days it was clear that this new regime was not working.*

6. *We urgently consulted with Prof Mark Solms, a professor of Neuro Psychology from the University of Cape Town and a family friend who had been helping Josh. He drafted a letter to the Trust which I sent the same day (on 15 November 2020) in which he confirmed that he was of the firm opinion that Joshua urgently needed to be put back onto an anti-psychotic medication and was displaying alarming psychotic symptoms. Importantly, at this stage, Joshua consented to restarting his anti-psychotic medication (including by injection if so advised).*

7. *At about this time, Joshua was then discharged from the Home Assessment Team and handed back to the Psychosis Team without warning or consultation with the family. I found out about that meeting from Josh at the last minute and attended by phone. At that meeting I made the point that what Joshua was telling the professionals was not what he was telling his family and we considered that he was a suicide risk. I said again that he urgently needed a psychiatric supervision since the change in medication was not working and he needed to be put back on an anti-psychotic. I made the point that since he had now been discharged from the Home Assessment Team, and our previous meeting with the psychiatrist had been cancelled at the last minute, that we would fall between the cracks at a critical time and it could take weeks to get another meeting. I was reassured that was not the case. At this stage i) there was no clarity or consultation with the family as to why Josh was not considered a suicide risk and had been discharged ii) no appreciation that he had been subject to a change of medication which required careful supervision*

8. *I kept on chasing for a meeting with his psychiatrist and one was finally arranged for the morning of the 25th November, some 10 days after I had sent the urgent letter. He committed suicide the day before that meeting.*

Hospital Admission

9. *There was no consideration of whether Joshua required hospitalisation by the Home Assessment Team (at least not in consultation with the family). After expressing serious suicidal intent on the evening of Saturday 21st November 2020, he was taken by my mother to the Lakes the following day. I participated in that consultation by phone since I live in London. The meeting was conducted by an excellent psychiatric nurse named* **[I/S]** *At one point Joshua made a disclosure in private to* **[I/S]** *which led her to believe that he was at real risk of suicide and was taking concrete steps. We do not know that nature of that disclosure, but it may be that he had*

obtained a drug from the internet to kill himself. At the meeting Joshua expressed a willingness to be admitted.

10. *She then consulted a member of the Home Assessment Team called* [I/S] *who overruled her assessment and declined to admit Joshua. He told Joshua that a change in medication take time to settle and that "**no psychiatrist in the world would prescribe him anti-psychotics in his current state**". I furiously expressed my alarm to* [I/S] *by what had just been said given that we had been working so hard to get him back onto his anti-psychotics. What was clear is that* [I/S] *assessment was made without consulting Joshua's notes, if he had he would have seen that his psychiatrist was planning to put him onto anti-psychotic depot injections and that there were repeated requests by his family to that effect.*

11. *Two days later Joshua committed suicide. At the time i) he had not been subject to proper psychiatric supervision even though he was undergoing a change in medication, ii) was not on anti-psychotics despite repeated urgent requests and iii) had been denied admission to hospital. We strongly believe that this failure of care directly caused Joshua's suicide.*

12. *The family need an answers to numerous questions from the Trust, including the following:*

    i. *Why was the request to urgently put him back onto anti-psychotics not actioned (especially in view of the urgent letter from Prof Solms)?*

    ii. *Why was the change in medication regime prescribed by Dr* [I/S] *not properly supervised by a psychiatrist, not least in view of Joshua's repeatedly stated suicidal intent?*

    iii. *Why did the Home Assessment team fail to consult with the family prior to discharge from the Team, despite Joshua's ongoing consent for us to be consulted?*

    iv. *What informed the decision making process of the Home Assessment Team, given that they had not consulted with the family?*

    v. *What was Joshua's disclosure to* [I/S] *on Sunday 22nd November 2020 at the Lakes which led her to the conclusion that Joshua was making plans to kill himself and that admission to hospital should be considered.*

    vi. *Why, on Sunday 22nd November 2020, did* [I/S] *from the Home Assessment refuse admission? What notes and information had been consulted by the Home Assessment Team given their apparent ignorance that Joshua's psychiatrist was recommending anti-psychotics by depot injection and urgent requests had been made to that effect by the family and Prof Solms?*

13. *These are our preliminary points of criticism of the Trust which we feel has failed Josuha. We feel a responsibility to speak out for others mental health*

patients who are at risk from such poor care. We have other criticisms such as:

vii. Why Joshua was never put on a s.117 Plan despite the fact that the Trust were under a statutory duty to do so, given that he had been under long term section in 2019.

viii. Related to that, why no psychological support or assistance into getting into volunteering or work was provided.

14. Finally, we would like to make it clear that we have no criticism of Joshua's care worker, **[I/S]** *who responded with care and kindness to the family and to Josh. Out criticism is of the psychiatric service and Home Assessment Teams for reasons we have set out above.*

15. We look forward to hearing from you as to how this complaint will be taken forward and how the family can feed their concerns into the investigation which takes place.

133. I do not recall the family being offered any support by EPUT. However, the family did engage with the internal investigation, and we met with EPUT investigators on two or three occasions to express our views and concerns.

134. I also followed up my initial letter from 29 November 2020, with a list of recommendations on 28 February 2021 as follows:

1. Recommendation 1 – the importance of effective and consistent Psychiatric supervision. In our view the fundamental cause of Joshua's death was a lack of proper psychiatric supervision. He had an ongoing issue of non-compliance with necessary medication and then spiralling out of control (in common with many sufferers of acute mental illness). Despite the family's urgent requests that he be put back onto anti-psychotics (backed up by Prof Mark Solms) which Josh agreed to, this did not happen. Indeed, he was discharged from the Home Assessment Team shortly before he killed himself without a proper psychiatric review even though he had been undergoing a change of medication (which was plainly not working). Overall, our experience was that he moved from one psychiatrist to another, none of whom had a proper understanding of Joshua's condition. <u>There is a need for consistent psychiatric care (with the same psychiatrist) and an early meeting with the patient's family (subject to patient consent) to discuss and agree the care plan from the outset</u>.

2. Recommendation 2 - Hospital admission – decisions must be taken only after all notes have been reviewed and discussions are held with the patient and his family. The fact that Joshua was refused hospital admission the weekend before he committed suicide is a scandal. That decision was made by a clinician who clearly had failed to properly consult Joshua's notes and had no interest in discussing the situation with the family before coming to his decision.

3. Recommendation 3 – The various more subtle forms of Psychosis need to be better understood. Joshua's psychosis was hard to detect since he spoke calmly and was careful to present well in front of medical professionals. It

was only after some time with Josh that it could be discerned that he was suffering from severe paranoia and delusions. That was the clear view of the clinicians who treated him while he was sectioned in London in 2019. Many of the clinicians at the Essex Trust he met quickly dismissed the possibility of psychosis (again seemingly without consulting his notes) because he did not immediately present as psychotic. It was only over time and after consultation with some family members that it was understood that he suffered from serious psychosis. The more difficult to discern forms of psychosis need to be considered and better understood prior to making clinical decisions.

4. *Recommendation 4 – the importance of Family consultation. It is understood that there are issues of patient consent which need to be navigated under the Mental Health Ac. However, Joshua had provided ongoing consent for the family to be consulted. Any yet the consultation with the family was entirely haphazard and disorganised. We would only find out about meetings on an ad hoc basis from Joshua – no effort was made to notify us directly. It was particularly difficult to get the Home Assessment Team to consult with us, but we were at the sharp of coping with Joshua and had information about his condition which was critical to clinical decision making. Further, Joshua was often providing inaccurate and unreliable information to the Clinicians (particularly about his compliance with medication) and this needed to be cross checked with the clinicians. There should be a concerted effort to involve and meet with the family at an early stage, to agree a care plan and cross check the information patients are giving before clinical decisions are made (on an ongoing basis).*

5. *Recommendation 5 – the need for holistic support. Joshua should have been on a s.117, and provided with holistic support. Irrespective of whether the Trust was in breach of its s117 duties, we believe that with the right support package, he could have got back on his feet and made a valuable contribution to society. As it was the only input he received from the Trust were short meetings with various psychiatrists who had little understanding of the complexities of his case. There was no support to get him into volunteering or employment or even to link him to the relevant organisations in question. His care worker was a kind and generous individual but only got involved when crises hit. Josh needed a comprehensive care plan, and help to connect to various organisations who could get him active and to start contributing to society. At the time he died Josh was waiting for psychical talking therapies and the support of a more proactive care worker who could get him to be more active. Had this been planned and done at the outset it could have made all the difference.*

6. *Overall, we feel that Joshua's death was a tragedy which plainly could have been avoided. He needed the right package of psychiatric and practical support to get settled and active in his life. It is our sincere hope that lessons are learnt from Joshua's death and patients are provided the support they need before they spiral out of control. This is not necessarily an issue of resources but of planning and consultation. Had things been properly planned and everyone fully consulted at the outset then a path could have been set which over time demanded less rather than more resources from the NHS."*

135. EPUT completed a Patient Safety Incident Investigation ('PSII') into the circumstances of Josh's death (report dated 28 October 2021). The report did little to engage with the substance of the letters we sent following Josh's death. On reading this report I was extremely disappointed to see that the Trust had concluded that no aspects of the service's involvement could be considered causative or contributory to Josh's death. The scope of criticism made in respect of his care was also very limited. Only four 'Care and Service Delivery Problems' were identified, which focussed largely on relatively more minor omissions. It was acknowledged that we as a family should have been offered a Carer's Assessment, in accordance with Trust procedure, and that Josh's s.117 rights were not reviewed following his transfer into EPUT. However, the key overriding failures, as I have outlined above, including Josh's medication management, care planning and the gatekeeping assessment on 22 November 2020, were not subject to any specific criticism. While several recommendations were made in the report – including the need to hold an MDT to consider risk management where a patient presents in a state of suicidal crisis – I do not believe these came close to addressing the repeated issues we had seen in his care.

136. Once the report was issued the EPUT Investigators offered to meet with us to discuss those recommendations, but as a family we saw little point in engaging with them further since they had largely failed to take on board our concerns, or dealt with them superficially and defensively.

137. I would characterise EPUT communications as polite and compassionate but the investigators were ultimately defensive and superficial and there was little real willingness to engage with the serious concerns we had raised.

Inquest touching upon Josh's death

138. An inquest into Josh's death was held at Essex Coroner's Court. After several Pre-Inquest Review hearings, the inquest was held on 8 to 11 July 2024 in front of HM Area Coroner Sean Horstead. The Coroner sought evidence from an independent expert psychiatrist, Dr Mynors-Wallis, who provided a detailed report and oral evidence at the inquest. I hope the Inquiry Legal Team will request disclosure of this report from us in due course, as it sets out a comprehensive analysis of the various failures and missed opportunities in Josh's care, which reflect the concerns we had and sought to raise at the time. Amongst various other issues, Dr Mynor-Wallis identified the following as significant failures: to implement a holistic care plan (which should have included medication, psychological treatment, social interventions and a safety plan), to put in place a detailed risk formulation (which should have included informed family involvement), to arrange hospital admission for Josh on 22 November 2020 and/or to provide him with a detailed safety plan. Dr Mynor-Wallis identified these three central failures as contributory to Josh's death. The contrast between these findings, and those of EPUT's PSII report, is very difficult to reconcile. This is a stark example of how 'marking their own homework' meant that the truth about their inadequate care remained hidden and unacknowledged by EPUT.

139. At the inquest hearing, the Coroner heard live evidence from a range of EPUT witnesses including:
    a. [I/S] Josh's care coordinator.
    b. [I/S] psychiatrist in the Specialist Psychosis Team.
    c. [I/S] psychiatrist in the Specialist Psychosis Team.
    d. [I/S] psychiatrist in the Home First Team.
    e. [I/S], mental health nurse in the Crisis Team.
    f. [I/S] mental health nurse in the Home First Team.

140. During his oral evidence about his assessment of Josh on 22 November 2020, Nurse [I/S] made the following significant statements:
    a. With the benefit of hindsight he had made the wrong decision and should have admitted Josh to hospital that day.
    b. He was unclear whether he had read any of Josh's medical notes before conducting an assessment of whether to admit him.
    c. During his assessment he had broken (his) own processes, and that he did not know why.
    d. He was disgusted with himself by the plan he outlined for Josh as an alternative to hospital admission that day (a plan which the Coroner went on to find did not outline anything other than an intention to update Josh's care coordinator, and did not include any safety netting). Nurse [I/S] admitted this was a very serious failure on his part to provide basic care.
    e. Nurse [I/S] disagreed with the family's view that he had come into the assessment with the firm opinion that Josh should not be admitted, and gave evidence to the effect that he had planned to admit Josh but changed his mind because he became flustered in the meeting.

141. It is a source of deep frustration for my family that none of the admissions made by Nurse [I/S] at the inquest had been elicited or identified in the PSII report, nor included in his own witness statement to the inquest. We felt that we had to fight for these admissions, through our legal team at the inquest, when these should have been accepted by the Trust, at the outset of the investigative process, as significant failures in respect of Josh's care and treatment.

142. The Coroner's conclusion at the inquest was highly critical of the care provided by EPUT. HM Coroner Horstead returned a short-form form of suicide contributed to by neglect, supplemented with the following narrative conclusion:

> "*The deceased (JL) suffered from a complex constellation of mental health disorders including Generalised Anxiety Disorder with Depression, a long-standing and continuing diagnosis of Ongoing Recurrent Psychosis and Schizoaffective Disorder. He had been known to Essex Partnership NHS Foundation Trust (EPUT) services since 2005 and had experienced often lengthy periods as a psychiatric in-patient in the UK, the USA and France including a last period prior to his death when he was detained under Section 3 of the Mental Health Act (MHA) 1983 at Highgate Hospital, London in May 2019. The evidence disclosed that when he regularly and consistently took anti-psychotic medication JL experienced extended periods of relative*

stability in his mental health; when he stopped taking such medication consistently his mental health deteriorated with his symptomatology presenting with increasingly delusional and persecutory thoughts and beliefs; his ascribing his mental health issues to organic causes (though all medical tests had confirmed no such underlying source); and a desire to 'flee' the geographical location he found himself located in.

Over the course of 2020, whilst he was under the care of EPUT's community-based Specialist Psychosis Team (SPT), JL's mental health steadily deteriorated as a consequence of his non-concordance with anti-psychotic medication and the symptomatology referred to above recurred. His family repeatedly raised their concerns with the EPUT team focussing on his non-concordance with medication and his presentation. The request by JL's family for Clinicians to consider the use of a monthly Depot injection to ensure medication compliance was not actively acted upon for a number of months.

Following an apparent brief hiatus in that deterioration in the summer of 2020 JL's condition significantly deteriorated further and for a short period in late October and early November (after an incident in which police attended JL's home and removed a length of rope with which he had expressed an intention to take his own life) he was under the care of the Home First Team (HFT). Notwithstanding concerns raised by the deceased's brother at a handover meeting on 12th November 2020 between the HFT and SPT regarding the deceased's on-going suicidal thoughts and non-concordance with medication, JL was stepped down from the (intensive care) of the HFT to the SPT.

On the 21st November JL's mother and brother separately contacted EPUT's Crisis Response Team (CRT) because of JL's continuing expression of suicidal thoughts. A face-to-face review was held with JL by a CTL Band 6 Psychiatric Nurse with his mother present in person and his brother participating by telephone. The outcome of the assessment was a referral for a 'Gatekeeping' assessment by another Band 6 psychiatric Nurse, a member of the HFT. In making her referral to Gatekeeping the CRT Nurse was clear that JL could not be kept safe in the community and required a period of admission as a psychiatric in-patient, something with which the family of JL whole-heartedly agreed and JL himself agreed. For reasons that remain largely inexplicable the Gatekeeping Nurse declined admission and, further, opined that JL did not require the support of the HFT. JL left instead, to return to his home address, where he was known to live alone, with simply a telephone number in the event of further deterioration. JL and his family expected a visit the following day, but no visit materialised. The purported up-dating of JL's Care Plan and the further documentation completed by the Gatekeeping Nurse following his assessment was accepted by him to be wholly inadequate.

JL's mother sent a text message to his Care Coordinator on the morning of the 24th November reiterating, again, her grave concerns, stating that JL was "on the edge of taking his life". The Care Coordinator called JL who told him that he felt suicidal and that he had a plan to hang himself, but the thought of his mother was preventing this. The Care Coordinator visited him that morning and JL expressed a wish to be provided with an antipsychotic medication. He was advised to take his anti-anxiety medication as prescribed. He accepted an offer to see the SPT Consultant Psychiatrist the following day. Later that afternoon JL was found by a neighbour suspended by his neck. His death was confirmed by attending ambulance personnel.

The following matters probably more than minimally contributed to JL's avoidable death:

a. *Although the Care Coordinator listened to and apparently acknowledged the concerns of the family as expressed to him over the course of 2020 there was, on the part of the SPT and HFT Psychiatrists involved in JL's care, insufficient practical action taken to robustly address those concerns with the aim of breaking the cycle of deterioration informed by JL's non-concordance with anti-psychotic medication and to develop an appropriately robust and thorough-going Care Plan or a clear and appropriately detailed and up-dated formulation of JL's risks. Specifically, there was a serious failure to discuss with JL his transition to a monthly Depot injection at a much earlier point in time given that the issue was repeatedly and consistently raised by JL's brother. This was a significant missed opportunity to break the cycle referred to.*

b. *In the light of the referral from the CRT Nurse, the subsequent decision not to facilitate JL's admission as an in-patient at the Gatekeeping assessment on the 22nd November 2020 was an erroneous one and made a more than minimal contribution to his death. The Nurse conducting the assessment apparently departed from his normal practice of inviting the CRT colleague who had recommended admission as an inpatient (with JL's consent and the agreement of the family) to participate in the assessment and to initially speak with the patient absent the family members. The Gatekeeping Nurse failed to appropriately prepare for the Gatekeeping exercise and consequently did not adequately appreciate the significance of JL's continuing non-concordance with antipsychotic medication previously prescribed to him over many years. The decision not to admit JL was an obvious and conspicuous missed opportunity to keep him safe at a point of clear and unambiguous mental health crisis.*

c. *There was a further failure, in the light of the decision not to admit JL, to put in place a plan to mitigate the significant risk of suicide that JL obviously presented on 22nd November. No support was offered beyond that already provided by the SPT and, as the documentary records confirm, there was simply nothing offered to JL or his family by way of a detailed crisis or safety plan in the face of JL's clear and on-going deterioration in his mental health that would begin to ameliorate the significant risk of suicide he presented. This was a very serious failure indeed, amounting to a gross failure to provide basic medical care and one that more than minimally contributed to the avoidable death of JL on the 24th November. On this basis the suicide of JL was contributed to by neglect."*

143. While I and my family welcomed the Coroner's robust conclusion, which reflected many of our own concerns about Josh's care, it is impossible for us to understand how starkly and fundamentally it contrasts with EPUT's own investigation into the Josh's death. The scope of the clinical failures identified by the Coroner concerning Josh's care – which, in respect of 22 November 2020, he considered so serious as to amount to neglect, which I understand is a very high threshold within coronial law – also brought

into relief for us as a family just how comprehensively Josh was failed by EPUT's mental health services. Knowing that his death was avoidable, in so many ways, remains a particularly painful reality for us to live with.

144. At the conclusion of the inquest, the Coroner deferred making any decision about whether to issue a Prevention of Future Deaths report until after EPUT had finished undertaking a full audit of all crisis services, which it indicated was ongoing, with the first phase due to be completed by the end of August 2024. We await a final decision from the Coroner on whether a Prevention of Future Death report will be issued, and we are hopeful the Coroner will do so to further highlight the failures by EPUT in Josh's care, and hopefully lead to improvements so other families don't have to go through what we have.

Rule 9 request

145. I address below where relevant and/or not already covered above some of the specific questions posed in the Rule 9 request from the Inquiry Legal Team.

Diagnosis & treatment

146. As set out in further detail from paragraph 8 above, Josh first became unwell and known to EPUT mental health services as a teenager when he received diagnoses of a schizoaffective disorder and a personality disorder. He later received further diagnoses including of recurrent depressive disorder, ongoing/recurrent psychosis, and mixed affective psychosis. A well-established pattern developed, from an early stage, that when Josh was particularly unwell it would coincide with increases in delusional and paranoid thinking. My family's and my strong view was that Josh suffered from an underlying psychotic illness, and that, because of this, he hugely benefited from antipsychotic medication (and significantly deteriorated when not taking it). This view was also shared by Professor Solms, as well as many of the mental health professionals who were involved in Josh's previous periods of inpatient admission. In addition to the failure by EPUT to take seriously and engage with our concerns that Josh was suffering from a psychotic illness, the fact that he did not, to our knowledge, undergo any diagnosis review whilst under their care, following his transfer back to the Trust in November 2019, was a further factor preventing Josh from receiving the appropriate diagnosis he required.

147. The independent expert psychiatrist Dr Mynors-Wallis, instructed as above in the inquest into Josh's death, found that, while there was some uncertainty about his exact diagnosis, on the balance of probabilities he had a psychotic illness. He notes for example that in 2019, while at Highgate Mental Health Hospital, Josh received a diagnosis of a delusional disorder, but that the EPUT consultant psychiatrists who saw Josh in the community following this did not identify a psychotic illness. As above, after hearing evidence from Josh's EPUT consultant psychiatrists and Dr Mynors-Wallis, the Coroner found that Josh:

"suffered from a complex constellation of mental health disorders including Generalised Anxiety Disorder with Depression, a long-standing and continuing diagnosis of Ongoing Recurrent Psychosis and Schizoaffective Disorder."

148. The Coroner found a number of failures with the care plan and treatment that Josh received. This evidence of Dr Mynors-Wallis was that the three major components of treating any psychiatric disorder are (1) medication; (2) psychological treatment; and (3) social intervention. My family's firm belief is that there were significant issues with each of these aspects of Josh's care plan and treatment, namely:

    a. We repeatedly raised concerns with EPUT professionals that Josh was not taking his antipsychotic medication and was clearly deteriorating as a result. Given Josh's difficulties with staying compliant with his medication, we requested that a depot injection antipsychotic be considered. The Coroner found that these requests were not acted on for a number of months, and depot injections were never discussed with Josh. I agree with the Coroner's description of this as a serious failure, which resulted in Josh continuing to decline throughout 2020 until he was in a state of crisis. This was compounded by the decision to take Josh off his antipsychotic medication entirely in late October 2020 and to prescribe him anti-anxiety medication instead which, despite having no recognisable positive therapeutic benefit on him, continued up until his death. That Josh had asked, the very day of his death, for a re-prescription of his antipsychotic medication and had, in recent days, agreed to trialling a depot, is, I believe, illustrative of his own recognition that such medication helped him, and that by then he urgently needed this help.

    b. I have read and agree with Dr Mynors-Wallis' view that psychological support could have been extremely helpful for Josh, particularly given his known reluctance to take medication. It was frustrating to read that Dr Mynors-Wallis could not understand why, in the last year of Josh's life, when he was under EPUT's care, there was not even an assessment for psychology involvement. I believe this would have significantly helped to explore and better understand the underlying triggers for Josh's non-compliance, as well as for his persecutory and delusional belief patterns.

    c. I also agree with Dr Mynors-Wallis' view that, while Josh had a care coordinator who provided him with some support, there was no clear and holistic care plan to help him develop meaningful daytime activities, employment or how to re-engage with his son. I believe those kinds of psychosocial interventions could have really helped Josh and given him something to look forward to and work towards, which is why I repeatedly asked for him to be allocated a support worker and why I repeatedly raised his entitlement to holistic case under s.117. It has never been explained to me why this was consistently ignored by EPUT.

149. These issues ultimately led to Josh reaching a point of crisis in late 2020, by when I believe the only way to have kept him safe would have been to admit him for a period

of inpatient treatment until he stabilised and was compliant with his medication. As above, despite the gatekeeping assessment on 22 November 2020, and repeated requests for inpatient treatment by our family, Josh was not admitted.

Assessment and admission

150. Josh was assessed for inpatient admission and admitted many times throughout his life, both while under the care of EPUT and by other mental health services in the UK, USA and France. I have already referenced these periods above, however I summarise the key details below so as to assist the Inquiry.

2010 to 2019

151. In around 2010/2011 Josh was detained under s.2 of the MHA 1983 for a lengthy period at Highgate Mental Health Hospital. This followed him becoming very unwell while in Peru. Further detail is set out at paragraph 11 above.

152. In around 2012, Josh became unwell while in upstate New York and was admitted for several weeks to a psychiatric hospital there (paragraph 13 above).

153. In the summer of 2018 Josh was detained in France as an inpatient for 10 days, but stabilised once he started to take his medication again. Shortly after returning to the UK, Josh was admitted to The Lakes Mental Health Hospital from 23 August until 10 September 2018. This followed a letter from my family to psychiatrist Dr [I/S] where we set out concerns about Josh's deterioration and our view that he needed to be detained until he had stabilised on his medication (paragraphs 19 to 20 above).

154. In 2019, following a deterioration in his mental health, Josh was detained under the MHA 1983 first at a ward in University College London Hospital, and then at Dunkley and Emerald Wards in Highgate Mental Health Hospital. Detail about this admission is set out at paragraphs 24 to 28. Following this admission, Josh moved back to Essex, where he lived in the community under the care of EPUT mental health services until his death.

2020

155. By the summer of 2020, my family and I saw Josh deteriorate significantly. We knew he had stopped taking his medication and he displayed many familiar symptoms of relapsing psychosis. As set out above, there were several occasions when we told EPUT professionals our firm view that Josh required a period of inpatient admission to stabilise and break the cycle. Josh continued to be very unwell and on 18 October 2020 he disclosed to our mother a specific plan to end his life with rope in his possession. Following this, we were informed that Josh was being referred to the Home First Team so he could be assessed for admission. Josh met with Dr **[I/S]** (consultant psychiatrist in the Home First Team) via video call on 20 October 2020, however he was not prescribed antipsychotic medication and he was not admitted to hospital. Further detail about this assessment is at paragraph 92.

156. Josh remained under the care of the Home First Team, and was again reviewed by Dr [I/S] on 30 October 2020, when his antipsychotic medication was discontinued and he was commenced on anti-anxiety medication. Josh was transferred back to the psychosis team on 12 November 2020. Further detail about Josh's care under the Home First Team is at paragraphs 93 to 103.

157. Josh remained very unwell and after further threats of suicide, on 22 November 2020 my mother took him to The Lakes Mental Health Hospital to be assessed, where and he was seen first by CPN [I/S] a Crisis Team mental health nurse, and then by nurse [I/S] from the Home First Team. The events of 22 November 2020 are set out in detail at paragraphs 111 to 121.

158. We as a family wholly agree with the Coroner's findings – and those of Dr Maynor-Wallis - as to the inadequacies of the 'gatekeeping' assessment conducted by CPN [I/S] on 22 November 2020. It was clear that Josh desperately needed a psychiatric admission at this point to stem his rapid deterioration and stabilise his medication regime (as his previous admissions had achieved). The decision by nurse [I/S] not to admit Josh, when he was in a state of such obvious crisis, and we as his family were begging for him to be admitted, remains as inexplicable to us as it was to the Coroner. The shock we experienced at being told Josh would not be admitted, so shortly after feeling the momentary sense of relief that he might finally be safe, when CPN [I/S] recommended his admission, was profound. We consider that the failure to admit Josh as an inpatient on this occasion was a critical missed opportunity to protect him, and to probably prevent his death.

159. The consequent failure by Nurse [I/S] to put in place any – or any adequate – care plan or safeguards for Josh's discharge back to the community was equally shocking to us. Josh was not found to meet the threshold for referral to the Home First Team (despite previously being open to them, and now in a state of suicidal crisis) and was discharged from hospital with no further support beyond what had already been in place for him from the Specialist Psychosis Team. Despite Josh's acute suicidal presentation by this point, Nurse [I/S] did not offer any form of crisis or safety plan, sending my mother and Josh home with a single phone number. We strongly support the Coroner's finding that this failure in care was so fundamental as to amount to neglect. If Josh and my family had been given proper support and safety-netting on his discharge, rather than being left feeling abandoned by the service which was supposed to protect him, I believe he would not have died in the circumstances he did.

160. However, it is also the case that all the professionals who were dealing with Joshua from June 2020 onwards should have listened to the family and taken more time to understand the severity of the crisis Josh was in and the spiral of deterioration we were dealing with. In reality, he should have been admitted to the hospital many months before he died to stabilise and to get back onto his mediation. There were repeated failures of all the collective services he encountered to recognise the seriousness of the situation and to take time to listen properly to the family.

Transfer and continuity of care and treatment in the community

161. I am concerned that many of the issues with Josh's care plan at the time of his death stemmed from when his care was transferred back to EPUT in November 2019. Josh was transferred from Camden and Islington NHS Trust back to Essex, when he was placed under the care of the EPUT North Essex Specialist Psychosis Team. As I have explained at paragraph 32 above, I was concerned that following his transfer to EPUT. no s.117 aftercare was arranged for Josh, which I hoped would lead to a long-term care plan to support him in the community. Camden and Islington NHS Trust were clear they had no power to help with this as Josh had moved to Essex, and his former psychiatrist from Islington wrote a letter to EPUT on 29 November 2019 to confirm Josh had needs requiring s.117 aftercare, explaining that this meant specialist psychosis services and supported accommodation would be appropriate.

162. By April 2020, EPUT still did not seem to have put in place the kind of holistic care plan and support (such as assisting in social interventions and accessing community activities) that I had understood should come with s.117 aftercare, as I raised with Dr **[I/S]** during a telephone call on 20 April 2020 (as at paragraph 44 above). I raised s.117 aftercare again with EPUT professionals in May 2020, including explaining on 21 May 2020 that as far as I was aware there was still no s.117 care plan. Even when I received an updated care plan for Josh dated 17 July 2020, it did not match what I understood he was entitled to as part of the s.117 aftercare package (paragraph 63 above). I again raised s.117 aftercare for Josh around September 2020, and asked his psychiatrists whether as part of arranging it, antipsychotic depot injections could be looked at (paragraph 74 above). On 13 October 2020 I raised (again) with Josh's care coordinator **[I/S]** my concern that he needed a support worker – which I believed would form part of a s.117 package – but by the time of Josh's death, still nothing had been put in place.

163. Despite repeatedly raising concerns about the package of care Josh received in the community (and that we believed he was entitled to under s.117 of the MHA 1983, after he was discharged from hospital in 2019), there never seemed to us to be a single care plan which would be effective at addressing Josh's composite needs.

164. In October 2020, when Josh was particularly unwell, he was transferred from the care of the EPUT Specialist Psychosis Team to their Home First Team. I understood that the purpose of the transfer was to assess whether Josh needed an inpatient admission and/or provide him with more intensive support in the community until he stabilised and could be transferred back to the Psychosis Team. The extreme difficulties with communication with the Home First Team and our frustrations with their decision making is set out above at paragraphs 89 to 103 above. My understanding is that patients are only transferred to the Home First Team when they need more intensive support, and it is very difficult to understand how almost completely shutting out a patient's existing support network – in Josh's case, his family with deep knowledge of his illness – could possibly be beneficial. We also found the process of discharge back to the Psychosis Team to be rushed, and poorly planned and there was a complete failure of

communication (paragraph 103). We had significant concerns that the transitions between the two teams impacted on Josh's continuity of care and resulted in key information and concerns being missed or misunderstood. It appeared to us that neither the Specialist Psychosis Team or Home First Team were willing to take ownership for Josh's care and to address his primary clinical needs, such as stabilising his medication compliance and reducing his significant risk profile. He was continually being moved between teams and different psychiatrists and ultimately no one saw what was obvious to the family, that Josh was not compliant with his medication, he was psychotic and deeply unwell and needed urgent and significant interventions to stabilise.

Engagement

165. Given the nature of Josh's illness, he very often had poor insight into just how unwell he was, and would often give professionals different information to what he told us. In contrast, as we were very involved with his care and treatment over a long period as his family we were well aware of the many familiar symptoms and patterns that recurred when his mental state started to deteriorate. We were therefore in the best position to identify when he was becoming particularly unwell, and the necessary safeguards and strategies to protect him. Josh had also given ongoing consent for us to be contacted and consulted about his care. Despite this, we were repeatedly ignored or not consulted when key decisions about Josh's treatment were made by EPUT. We also often only found out about decisions and meetings after the event, even where they had been prompted by concerns we had raised about Josh.

166. We had to fight to be included in review meetings (often without success) and to have our voices heard (again, often without success, with our key about Josh's suicidality and his need for a depot injection not registering until it was too late). Nurse **[I/S]** outright dismissal of our concerns, during the assessment on 22 November 2020, despite our pleading for Josh to be admitted, is starkly illustrative of this. To say that EPUT was reactive, rather than pro-active, in their engagement with us as a family would be a significant under-statement: they were entirely non-responsive, failing to respond to, let alone seek out, our concerns and proposals. I believe that we were seen by the service as a source of frustration and obstruction, rather than an invaluable resource and support base for their patient. I have set out in detail above the many occasions we experienced being shut out or sidelined by Essex's mental health services and will not repeat them again here.

Recommendations for change

167. We hope that the Lampard Inquiry will lead to lasting and meaningful change so that no family has to go through the same loss we have. In this context, we therefore urge the Chair to carefully consider implementing the following recommendations.

168. First, **Family consultation**. We urge the Chair to consider specific recommendations addressed at improving the Trust mechanisms and policy framework concerning the involvement of and information-sharing with family members. We know we are not the only family who is urging this. This is vital to avoid the experience we had of being

repeatedly ignored and/or not consulted about key decisions, despite our extensive experience and knowledge of Josh's illness. The issues we faced with being dismissed or shut out of Josh's care came from a range of professionals and different teams within EPUT. In our view the failures we experienced in engaging with the Trust were so deep-rooted that it was akin to an institutional culture. We therefore invite recommendations that acknowledge and address this defensive culture in the Trust, which appears to perpetuate unhelpful and polarising attitudes about the role of family members and loved ones in a patient's care.

169. Second, **Martha's Rule**. I am aware that in May 2024 NHS England announced the implementation of a pilot at some Trusts of 'Martha's Rule' – a new initiative which gives patients and families a way to seek an urgent review if their loved one's condition deteriorates and they are concerned this is not being responded to appropriately[1]. Given its already positive early response in Trusts where it is has been piloted[2], I understand that there is an intention to expand Martha's rule to all NHS Trusts, including community and mental health providers, but that there is no date yet and it is subject to the government confirming funding. If a mechanism to have Josh's care and treatment reviewed existed in 2020, it could have helped to ensure we were listened to and that he received the care he needed. We invite the Chair to make a recommendation that Martha's Rule be rolled out nationally and be made available to mental health services.

170. Third, **continuity of psychiatric supervision**. In our view the fundamental cause of Joshua's death was a lack of proper psychiatric supervision. He had an ongoing issue of non-compliance with necessary medication and then spiralling out of control (in common with many sufferers of acute mental illness) and this was never really understood by the multiple professionals he encountered. There is a need for a commitment to consistent psychiatric care (with the same psychiatrist) and an early meeting with the patient's family (subject to patient consent) to discuss and agree the care plan from the outset. Whilst we recognise that resources, holiday, shift patterns etc can be a challenge to consistency, our experience is that there was no attempt at continuity; compounded by the fact that not all practitioners review the relevant records before taking decisions, despite a professional duty to do so.

171. Fourth, the need for **holistic support**. Together with family consultation at the outset of a patient's assessment by EPUT there should be consideration for multi-agency holistic support. With the right support package, we are firmly of the view that Joshua could have got back on his feet and made a valuable contribution to society, and the same no doubt applies to many other people with mental illness. The holistic support should cover, as a minimum, housing support/advice, volunteer work, life skills training and pathways into work. Whilst this has resource implications, the failure to provide it has much greater resource consequences.

---

[1] NHS England, Patient Safety, "Martha's Rule": https://www.england.nhs.uk/patient-safety/marthas-rule/

[2] NHS England, News, "Martha's Rule 'already saving lives' in NHS hospitals", dated 17 December 2024: https://www.england.nhs.uk/2024/12/marthas-rule-already-saving-lives-in-nhs-hospitals/

172. Fifth, the **internal Trust investigation processes**. We would also like the Chair to consider what changes could be made to the investigation processes following a patient death to prevent the kind of conflicting investigation conclusions we received in Josh's case. Internal investigations by NHS Trusts following a death cannot be effective or valuable if they do not identify, in a transparent and collaborative manner, the failures which led to a patient's death, as well as the key evidence or admissions by their staff, as well as an explanation as to why these failures occurred, and the steps being taken to rectify them. Not only does an inadequate or limited internal report prevent the Trust from identifying effective learning, in order to ensure that the same pattern of failures do not recur, but it will often have a bearing on the course of subsequent investigations, such as inquests, if key evidence or issues have not been uncovered at an early investigative stage. We are also aware that the inquest process may not always expose the wrong-doing and can be dependent on who the Coroner is. Furthermore, families often wait a very long time for an inquest to be heard, and a proper, robust, truthful internal investigation would at least give families some answers. We note that a number of other families have this same complaint about the wholly inadequate internal investigation, whose inadequacy only comes to light if they are legally represented in a robust inquest process. With this in mind, we would invite the Chair to consider closely making recommendations and findings in relation to EPUT and the enforcement of the duty of candour.

173. Sixth and finally, **National Oversight Mechanism**. We are very concerned that the failures in care which contributed to Josh's death may have been identified by previous investigations, including through Coroner's Prevention of Future Death Reports in similar deaths. Given the absence of any central mechanism for overseeing the monitoring and implementation of such reports, it may well be that similar thematic concerns were identified against EPUT before, and action recommended, however nothing was done. We wholeheartedly endorse INQUEST's campaign for a National Oversight Mechanism, as an independent body responsible for collating, analysing and following up on recommendations arising from inquests and other types of investigations into state-related deaths. We believe this is a crucial safeguard to break the cycle of preventable deaths and harms which occur within the mental health setting and other sites of vulnerability. We also consider that the CQC, as the healthcare regulator should be apprised of all relevant PFD reports made by a Coroner.

List of documents

174. As requested by the Inquiry I have included below a list of documents in our possession in relation to Josh's care and treatment. These can be readily provided to the inquiry if requested.

List of Documentation in the Leader Family's Possession		
Item	**Date**	**Document Title**
A. Witness Statements		

1.	08/11/21	A57 Police Report Inspector [I/S]
2.	05/12/20	Police Statement of Inspector [I/S]
3.	24/11/20	Police Statement of PC [I/S]
4.	24/11/20	ROLE Statement of [I/S] (Paramedic)
5.	26/02/21	Statement of [I/S] (Care Co-ordinator)
6.	14/04/21	Statement of [I/S] (Locum Consultant Psychiatrist).
7.	22/07/21	Statement of [I/S] (HFT Consultant Psychiatrist)
8.	26/06/21	Statement of [I/S] (CRT Mental Health Nurse)
9.	24/06/21	Statement of [I/S] (HFT Psychiatric Nurse)
10.	30/06/21	Statement of [I/S] Registered Mental Health Nurse)
11.	21/10/21	Statement of [I/S]
12.	15/09/21	Statement of [I/S]
13.	02/11/21	Statement of [I/S]
14.	12/11/21	Statement of Professor Mark Solms
15.	16/08/20	Exhibit MS/1 to Statement of Professor Mark Solms: Email from Joshua Leader to Professor Mark Solms.
16.	18/08/20	Exhibit MS/2 to Statement of Professor Mark Solms: Letter from Professor Solms to Camphill UK.
17.	18/08/20	Exhibit MS/3 to Statement of Professor Mark Solms: Email from Joshua Leader to Professor Mark Solms.
18.	19/08/20	Exhibit MS/4 to Statement of Professor Mark Solms: Email from Joshua Leader to Professor Mark Solms.
19.	17/09/20 to 18/09/20	Exhibit MS/5 to Statement of Professor Mark Solms: Emails between Joshua Leader and Professor Mark Solms.
20.	26/09/20	Exhibit MS/6 to Statement of Professor Mark Solms: Email from Professor Mark Solms to Joshua Leader.
21.	27/09/20	Exhibit MS/7 to Statement of Professor Mark Solms: Emails between Daniel Leader and Professor Mark Solms.
22.	14/10/20 to 17/10/20	Exhibit MS/8 to Statement of Professor Mark Solms: Emails between Joshua Leader, Professor Mark Solms and Daniel Leader.
23.	21/10/20	Exhibit MS/9 to Statement of Professor Mark Solms: Email from Joshua Leader to Professor Mark Solms.
24.	28/10/20 to 29/10/20.	Exhibit MS/10 to Statement of Professor Mark Solms: Emails between Joshua Leader and Mark Solms.
25.	30/10/20	Exhibit MS/11 to Statement of Professor Mark Solms: Emails between Joshua Leader and Professor Mark Solms.
26.	30/10/20	Exhibit MS/12 to Statement of Professor Mark Solms: Emails between Joshua Leader and Professor Mark Solms.
27.	01/11/20	Exhibit MS/13 to Statement of Professor Mark Solms: Email from Joshua Leader to Professor Mark Solms.

28.	11/11/20	Exhibit MS/14 to Statement of Professor Mark Solms: Emails between Joshua Leader and Professor Mark Solms.
29.	15/11/20	Exhibit MS/15 to Statement of Professor Mark Solms: Letter from Professor Mark Solms to Daniel Leader.
30.	28/02/23	Statement of Daniel Leader
31.	28/08/018	Exhibit DL/1 to Statement of Daniel Leader: Family letter to psychiatrist [I/S]
32.	25/11/19	Exhibit DL/2 to Statement of Daniel Leader: Letter from psychiatrist [I/S] to the North Essex Specialist Psychosis Team
33.	17/03/20 to 30/11/20	Exhibit DL/3 to Statement of Daniel Leader: Text messages with [I/S] Care Coordinator
34.	26/05/20	Exhibit DL/4 to Statement of Daniel Leader: Joshua Leader's updated care plan.
35.	17/07/20	Exhibit DL/5 to Statement of Daniel Leader: Joshua Leader's updated care plan.
36.	14/10/20	Exhibit DL/6 to Statement of Daniel Leader: Email from Josh to Professor Solms.
37.	15/11/20	Exhibit DL/7 to Statement of Daniel Leader: Letter from Professor Solms forwarded to Care Coordinator.
38.	03/03/23	Statement Florence Leader
39.	07/09/22	Statement of [I/S] (Head of Electronic Systems, Records and Information Governance for EPUT)
40.	04/07/24	Statement of [I/S] (Deputy Director North East Essex Community Services)
41.	11/07/24	Statement of [I/S] (Associate Director for Urgent Care and Inpatient Services for North Ease and West Essex at EPUT).
42.	Undated (received 08/10/24)	Statement of [I/S] (Deputy Director, Quality & Safety – Inpatient and Urgent Care) and [I/S] (Associate Director of North East Essex Community and Dementia Services)
B. Medical Reports and Exhibits		
43.	08/11/21	A57 Police Report Inspector [I/S]
44.	03/12/20	Preliminary Postmortem Report of [I/S]
45.	03/02/21	Supplementary Postmortem Report of [I/S]
46.	13/01/21	Toxicology Report of [I/S]
47.	17/03/20 to 30/11/20	Text messages CC and Dan Leader (brother)
48.	13/05/20 to 07/12/20	Text messages - CC and Florence Leader (mother)
49.	28/10/21	Essex Partnership University NHS Foundation Trust (EPUT) Patient Safety Incident Investigation (PSII) Report
50.	09/08/10 to 27/11/20	Medical Summary

51.	02/07/20 to 03/03/21	Previous Consultations from GP at Wivenhoe Surgery.
52.	01.11.2019 to 24/11/20	Full Medical Notes and Consultations Bundle (Redacted)
53.	24/11/20	East of England Ambulance Service (CAD-Redacted)
54.	24/11/20	EEAS Patient Care Record
55.	15/06/23	Medical Report of Dr L Mynors-Wallis
C. Policies and Procedures		
56.	30/03/20	Crisis Response and Home First Model.
57.	19/06/19	Clinical Risk Assessment Safety Management Policy (Version 3)
58.	26/05/17	CPA Procedure.
59.	Undated	Pan Essex s117 Protocol.
60.	01/20	Suicide Prevention Clinical Guidelines.
61.	19/06/19	Clinical Risk Assessment Safety Management Procedure (Version 3.2)
62.	10/20	Carers Assessment Support Policy.
63.	03/18	Specialist Psychosis Team Operational Policy
64.	19/06/24	Appendix C – EPUT Safety Action Plan
D. Correspondence		
(a) Bundle of Correspondence Received from the Leader Family (as at 26/08/21)		
65.	28/08/18	Emails between Daniel Leader and [I/S] secretary)
66.	28/08/18	Letter from Leader family requesting Joshua Leader Mental Health Act detention
67.	29/08/18	Email from Daniel Leader to [I/S] secretary)
68.	30/08/18	Email from [I/S] secretary) to Daniel Leader
69.	10/09/18	Letter from [I/S] regarding Joshua Leader housing
70.	10/09/18	Letter from [I/S] regarding Joshua Leader referral to specialist psychosis team
71.	26/06/19	Email from [I/S] (HMHC) attaching letter from [I/S] [I/S]
72.	26/06/19	Letter from [I/S] confirming Joshua Leader admission and detention
73.	17/07/19	Email from Daniel Leader to [I/S] (HMHC) discussing Joshua Leader accommodation and care plan
74.	18/07/19	Email from [I/S] (HMHC) to Daniel Leader discussing accommodation and care
75.	22/07/19	Email from Daniel Leader to [I/S] (HMHC) discussing Joshua Leader accommodation
76.	23/07/19	Email from [I/S] (HMHC) discussing Joshua Leader accommodation

77.	04/09/19	Email from Daniel Leader (unclear who to) with formal complaint regarding accommodation
78.	15/11/19	Emails between Daniel Leader and [I/S] regarding telephone call
79.	22/11/19	Email from Daniel Leader to [I/S]
80.	25/11/19	Emails between Daniel Leader and [I/S]
81.	25/11/19	Letter from [I/S] to Essex Trust
82.	14/05/20	Email from Florence Leader to CC forwarding list of symptoms from Joshua Leader
83.	19/09/20	Email from Joshua Leader to Daniel Leader and Prof. Mark Solms
84.	19/09/20	Health questionnaire from [I/S]
85.	20/10/20	Email from Florence Leader to CC discussing Joshua Leader presentation and suicide attempt
86.	15/11/20	Letter from Professor Mark Solms to Daniel Leader recommending antipsychotic medication for Joshua Leader
87.	20/11/20	Email from CC attaching anti-psychotic medication leaflets
88.	20/11/20	Clopixol Injection leaflet
89.	20/11/20	Clopixol leaflet
90.	20/11/20	Depixol injection leaflet
91.	20/11/20	Depixol tablets leaflet
92.	29/11/20	Letter from Leader family requesting investigation into Joshua Leader death
93.	01/03/21	Leader family recommendations to the Essex NHS Trust
(b) Schedule of Text Messages dated 17/03/20 to 07/12/20		
94.	17/03/20 to 07/12/20	Schedule of text messages between CC and Joshua Leader, Joshua Leader's brother (Daniel Leader), and Joshua Leader's mother (Florence Leader) in date order.
(c) Bundle of Email Correspondence		
95.	21/09/20 to 24/11/20	Email correspondence of [I/S]
96.	20/10/20 to 30/10/20	Email correspondence of [I/S]
97.	16/01/20 to 19/05/20	Email correspondence of [I/S]
98.	12/12/19 to 24/11/20	Email correspondence of [I/S] with professionals.
99.	14/04/20 to 24/11/20	Email correspondence of [I/S] with family.
100.	26/06/20	Email correspondence of [I/S]
(d) Bundle of Professor Solms Correspondence		
101.	18/08/20 to 18/11/20	Bundle of Professor Solms Correspondence
E. Other Inquest Documents		
102.	Undated	Family Pen Portrait

103.	08/07/24 to 11/07/24	Inquest Attendee List and Witness Running Order
104.	11/07/24	Record of Inquest

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: **[I/S]**

.....

DANIEL LEADER

Date: 14/07/2025

.....