

1 Wednesday 15 October 2025

2 (10.03 am)

3 MR COKE-SMYTH: Good morning, Chair. Today we return to
4 hearing evidence from the bereaved families of those who
5 died while under the care of trusts in Essex. This
6 morning we will hear from brothers Alexander and Paul
7 Guille. They will be giving evidence about their sister
8 Bethany Lilley who died on 16 January 2019, aged 28.
9 This afternoon we will hear from Jane Stanford. She will
10 be giving evidence about what happened to her mother
11 Dorothy Reditt who died sometime between 15 and 16 March
12 2021, aged 85. Both sessions will include details of the
13 care and treatment they received or the care and
14 treatment received by those who died, and it will also
15 involve include some detail of how they died. It is
16 right to say that there may be aspects of today's
17 evidence that are difficult to listen to. For some
18 people it may not be possible to sit through the two
19 sessions and as with other days, anyone in the Inquiry
20 room should feel free to leave at any time.

21 May I also take this opportunity to remind
22 those engaging with the Inquiry that emotional support is
23 available for all who require it. Present here again
24 today are emotional support staff from Hestia, an
25 experienced provider of emotional support at these types

1 of hearing. They are currently in this room and they are
2 identified by orange-coloured scarves or lanyards. There
3 is also a private room downstairs where anyone who needs
4 emotional support can talk to Hestia support staff and if
5 you prefer you can speak to a member of the Inquiry team
6 and we will put you in touch with the emotional support
7 staff wearing purple-coloured lanyards. For those
8 following the hearing online, information about the
9 emotional support that is available can be found on the
10 Lampard Inquiry website at lampardinquiry.org.uk and the
11 support tab is near the top right-hand corner. We want
12 everyone engaged in this Inquiry in whatever way to feel
13 safe and supported.

14 Chair, with that introduction, we have ready to
15 begin Alexander and Paul Guille. Perhaps they can be
16 sworn first.

17 ALEXANDER GUILLE (sworn)

18 PAUL GUILLE (sworn)

19 Examination by MR COKE-SMYTH

20 Q. Can I ask you both to tell the Inquiry your full names?

21 A. PAUL: Yes, I am Paul Nathan Guille.

22 A. ALEX: I am Alexander Jabez Guille.

23 Q. Paul, can I start with a brief apology for the fact that
24 you were referred to in the opening as Peter. Of course,
25 we do know you are Paul, so our apologies. It's right

1 that you are the older brothers of Bethany Lilley who you
2 called Beth?

3 A. PAUL: Yes.

4 Q. Can I ask are you content for me to refer to her as Beth?

5 A. ALEX: Yes.

6 A. PAUL: Yes.

7 Q. Beth died on 16 January 2019 whilst an in-patient at the
8 Thorpe Ward part of the Basildon Mental Health Unit. Can
9 I just check how you would both like to be referred to?

10 A. PAUL: Paul.

11 A. ALEX: Alex.

12 Q. Thank you. Now you have prepared a witness statement
13 which I hope you should have in front of you. It runs to
14 75 pages and it is dated 3 June 2025, and it is signed
15 and it contains a declaration that the facts contained in
16 it are true. Can I start, please, just by dealing with
17 one matter which you raised this morning. You raised a
18 correction to your statement, just a point of accuracy,
19 at paragraph 10.7. So for anyone looking at page numbers
20 that's page 44, and the first line there refers to "the
21 Lakes", and you have confirmed that in fact that's a
22 mistake. That should read "Thorpe Ward", is that right?

23 A. PAUL: Yes, apologies we didn't catch it sooner.

24 A. ALEX: Yes, that is correct.

25 Q. No problem at all. Now with that correction, can I just

1 confirm then that the statement is true to the best of
2 your knowledge and belief?

3 A. PAUL: It is, yes.

4 A. ALEX: Yes.

5 Q. Thank you. Now, I should emphasise that this statement
6 will stand as your evidence. It's a very full, it's a
7 very detailed statement and although I am going to take
8 you through the statement, please rest assured that if I
9 don't mention something or ask about a particular point
10 or don't cover it, it is still there, it is still part of
11 your evidence. It is also right that you have provided a
12 commemorative and impact statement to the Inquiry
13 previously?

14 A. PAUL: Yes.

15 Q. Now just dealing with the statement, how you have made
16 it, it is right you have given as full an account as you
17 can and some of it is based on your own recollections and
18 impressions. Is that right?

19 A. PAUL: Yes.

20 Q. But it also includes recollections and impressions of
21 other family members, in particular your mother Julia.
22 Is that right?

23 A. PAUL: Yes.

24 Q. And also your sister Sarah?

25 A. PAUL: Yes.

1 Q. And it is right that they are both here today at the
2 Inquiry?

3 A. ALEX: So Joanne is present.

4 Q. Sorry, forgive me, but you have provided a statement on
5 behalf of the family?

6 A. PAUL: Yes.

7 A. ALEX: Yes.

8 Q. And you have also based it on documents, some of those
9 documents you weren't aware of at the time but you have
10 been provided subsequently, is that right?

11 A. PAUL: That's right, yes.

12 Q. And at the outset of your evidence, can I just take the
13 opportunity to summarise and deal with some of the most
14 important aspects in terms of dates and care. Bethany
15 died, or Beth, died at the age of 28 on Thorpe Ward
16 whilst an in-patient on 16 January 2019. But it is right
17 to say her first admission as an in-patient was some
18 three years previously, and that was to the Ardleigh Ward
19 at The Lakes, and that was January 2016?

20 A. PAUL: Yes.

21 Q. And she was aged, would be have been aged 25 for that
22 first admission?

23 A. ALEX: Yes.

24 Q. Now just to summarise, between that first admission in
25 January 2016 and January 2019, she was admitted as an

1 in-patient to various mental health units, a total of
2 eleven times, I count from your statement. Does that
3 sound right?

4 A. PAUL: Sounds about right, yes.

5 A. ALEX: Yes.

6 THE CHAIR: Sorry, can I just ask what was her date of birth?

7 A. ALEX: It is 12 September 1990, is that correct?

8 A. PAUL: That is right, yes.

9 MR COKE-SMYTH: In the course of those eleven admissions,
10 again, just summarising from your statement, two of those
11 were under section 2 of the Mental Health Act, there were
12 four occasions where she was also detained, so section 2
13 detained for assessment, and then four occasions she was
14 detained under section 3 of the Mental Health Act for
15 treatment; is that right?

16 A. PAUL: Yes, that is right.

17 A. ALEX: Yes.

18 Q. And just to summarise, although Beth was diagnosed with
19 emotionally unstable personality disorder when first
20 admitted at The Lakes, you also highlight that another
21 key problem for Beth was drug addiction, is that right?

22 A. PAUL: Yes.

23 Q. And a key concern that you articulate in your statement
24 is that throughout this period there was an emphasis on
25 simply treating Beth's physical symptoms?

1 A. PAUL: Yes.

2 A. ALEX: Yes.

3 Q. With a view to discharging her rather than trying to
4 properly understand the underlying issues in her case?

5 A. ALEX: Yes.

6 Q. And you also wholeheartedly agree in your statement with
7 the findings of the independent investigation and report
8 into Beth's care and they said this, which you quote in
9 your statement, paragraph 7.5, page 37, their conclusion
10 was that there was:

11 "No holistic formulation was developed that
12 took into full account ... [Beth's] emotional, physical,
13 mental health and social needs'."

14 And you go on to quote the report's conclusion
15 that:

16 "The lack of a robust diagnostic formulation,
17 in our view, was the most probable cause for the failure
18 of all subsequent care and treatment ..."

19 Am I right that's a sentiment you very much
20 agree with?

21 A. PAUL: Yes, absolutely, I think lots of the evidence we
22 will be looking at today will very much support that, in
23 our view.

24 Q. It is also right to say that at the subsequent inquest
25 into Beth's death, the inquest which sat with a jury,

1 they also found as part of their narrative conclusion
2 that there was a failure in the diagnostic formulation
3 process, amongst other failings?

4 A. PAUL: Yes.

5 A. ALEX: Yes.

6 Q. The other point I want to take you to from the
7 independent report which you cite is page 48, 12.8, and
8 it is the penultimate line at the bottom of the page and
9 it concluded this:

10 "None of the interventions over the three year
11 period that Beth was under the care of mental
12 health services served to improve her situation - it is
13 incontrovertible that she continued to grow worse.
14 Obviously the reasons for this were multifactorial -
15 however the treating teams should have recognised at a
16 much earlier stage that the approach which kept being
17 rolled out over and over again was ineffective and able
18 to effect change."

19 Again just pausing there, is that a conclusion
20 which again you wholeheartedly agree?

21 A. ALEX: Yes.

22 A. PAUL: Yes.

23 Q. So just by way of introduction, in short, despite all
24 those admissions, 11 in total, and discharges, not only
25 did Beth's mental health not improve, in fact, as we are

1 about to hear , it significantly deteriorated?

2 A. PAUL: Yes.

3 A. ALEX: Yes.

4 Q. I am going to now turn to the first part of your
5 statement and I am planning to go through the statement
6 as it is structured, so dealing first with the
7 chronology, and I hope to get through that before the
8 mid-morning break, before picking up the second part of
9 the statement, where you deal with some themes and also
10 recommendations. So can I start, please, where you deal
11 with background facts. This is part 1 of your statement
12 and just dealing with some of Beth's background to start
13 off with. As the Chair has noted, Beth was born
14 September 1990 and she was the youngest of six siblings,
15 a younger twin, and you are her older brothers; is that
16 right?

17 A. PAUL: That's correct.

18 Q. Her father was Dr John Guille who was a GP?

19 A. ALEX: Yes.

20 Q. And her mother Mrs. Julia Guille. Her parents separated
21 when Beth was 12 and she was diagnosed with ADHD at 16,
22 and you describe her in the statement as a very caring
23 individual, someone who was fiercely loyal to friends.
24 Is that right?

25 A. ALEX: Yes.

1 A. PAUL: Yes, absolutely.

2 Q. You also describe her as somebody who adored her nephews
3 and nieces, am I right there were a number?

4 A. ALEX: Yes, there's quite a number of us and like the
5 siblings there's six of us in total and so we have got
6 quite an extended family and, you know, Bethany would
7 always be involved, and she was very caring, very loving.

8 Q. And you describe how she found academic work difficult
9 and left school at 16 with 5 GCSEs. She started to study
10 to become a nurse in 2014 but, unfortunately, didn't pass
11 the academic segments assignments and she was also
12 diagnosed at about the same time with dyslexia, is that
13 right?

14 A. ALEX: Yes.

15 A. PAUL: Yes, that is right.

16 Q. She also worked as a healthcare assistant and
17 phlebotomist at your father's surgery from around 2012,
18 is that right?

19 A. ALEX: Yes.

20 Q. Is that something she enjoyed?

21 A. PAUL: Absolutely, yes, I think we mention it in the
22 statement that again it comes back to, as you were just
23 mentioning, what she was like with her nieces and
24 nephews. I think that caring part of her personality
25 pervaded everything she did. So yes, she absolutely

1 loved, the opportunity to work with people, connect with
2 people and help people.

3 A. ALEX: And as a health assistant she would do a lot of
4 work, you know, with kind of elderly patients and they
5 absolutely loved her, you know, when I was working for
6 dad at the time as well at the surgery and yes, she was
great, she was absolutely super at that role.

8 It was just unfortunate that, you know, to kind of
9 progress further it required this kind of academic
10 aspect, I guess, that nursing and things require, doesn't
11 it? So ...

12 Q. And in 2015 she married her childhood sweet heart, is
13 that right?

14 A. PAUL: Yes.

15 Q. Although they sadly separated later on during a period of
16 intense mental illness?

17 A. ALEX: Yes.

18 Q. Turning then in terms of background and Beth's teenage
19 years, and just to summarise, there was some contact with
20 CAMHS as a teenager and the records show an overdose when
21 she was 15, but is it right to say that it wasn't until
22 later, from around about the end of 2015, early 2016,
23 that Beth's mental health problems really began to
24 emerge. Is that a fair summary?

25 A. ALEX: Yes.

1 A. PAUL: Yes, I think the evidence focused mostly on those
2 2016 to 2019 years in particular so yes, definitely.

3 Q. And so jumping forward, then, to 2016, when Beth would
4 have been 25, we see reference in your statement looking
5 from paragraph 5.4, you set out there some of the initial
6 interactions with mental health services, and the
7 circumstances which led to her first admission to
8 Ardleigh Ward at The Lakes. So just summarising the
9 background there, she had attended an A&E and she was
10 initially, that was as a result of self-harm, is that
11 right?

12 A. PAUL: Yes.

13 Q. And as you point out there, that was something which
14 continued for quite some time. You describe that in 2006
15 she in fact attended A&E 23 times for acts of self-harm
16 ranging from overdoses to deliberate self-harm by way of
17 lacerations. We see she was admitted to Ardleigh Ward on
18 The Lakes between 17 January 2016 and 3 February 2016,
19 and it is here, isn't it, that she received her first
20 formal mental health diagnosis, is that right?

21 A. PAUL: Yes, that's right.

22 A. ALEX: Yes.

23 Q. And you set out there, and again worth emphasising, you
24 have seen this subsequently from the records, but is it
25 fair to say perhaps weren't quite as aware at the time of

1 the detail you have put in here about what was in fact
2 diagnosed?

3 A. PAUL: Yes, I remember her coming home from that specific
4 appointment and, like, sharing it with us, but, like,
5 beyond that we didn't really understand the implication
6 of that and just what it would end up becoming, really.
7 So yeah, it's definitely been, like, the process of
8 looking back through the documents has been what's really
9 helped to shed a light on what was truly going on, I
10 suppose.

11 Q. And the official diagnosis recorded was for emotionally
12 unstable personality disorder. That was on 18 January
13 2018 -- sorry, 2016?

14 A. PAUL: Thank you.

15 Q. And we see that that diagnosis was later accepted in a
16 subsequent assessment in May 2016, but I think as we have
17 touched upon from the independent report, although there
18 was a diagnosis, you and indeed that report are critical
19 as to the extent to which that was explored and that was
20 used to inform her care. Is that right?

21 A. ALEX: Yes.

22 A. PAUL: Yes, absolutely. I think this was for me, maybe
23 it's a bit early to be saying this, but this for me marks
24 the start of this sort of revolving door policy where it
25 was very much a patch up and send her back out kind of

1 approach is often how it felt, so I think, yeah, that
2 lack of the overarching care plan, like you say, I think
3 starts to become really evident at this point.

4 THE CHAIR: Did she understand that diagnosis, did you
5 understand that diagnosis?

6 A. PAUL: I don't think -- there is a history of mental
7 health in our family so we understood there was some
8 similarities with it being a personality disorder
9 specifically, but yes, so I suppose we had some
10 understanding, certainly through one of our family
11 members was with the Haven Project which specifically
12 supports people with personality disorders. So I think
13 we -- they did quite a good job of educating families and
14 giving like pamphlets and things to outline what a
15 personality disorder looks like. So we were very lucky
16 in that we kind of had some grounding of what it was.

17 THE CHAIR: But EPUT itself had not explained?

18 A. PAUL: No, not to us and, yeah, we got it fed back from
19 Bethany and that's my memory of it anyway.

20 THE CHAIR: Did you think that Bethany had been given some
21 understanding?

22 A. PAUL: I can't, I wouldn't, I don't think so. It's hard
23 to say, of course, I was not in the appointment but it
24 didn't feel like that.

25 MR COKE-SMYTH: So that's the initial diagnosis and she was

1 initially an informal patient and spent between 17
2 January, 3 February. She was then discharged and we can
3 see that she then attended the Haven Project, which I
4 think you just referred to.

5 A. PAUL: Yes.

6 Q. And that's an organisation which assists those with EUPD,
7 is that right?

8 A. Yes, I think it's personality disorders generally, but
9 yes.

10 Q. And she was also under the care of a team called the Home
11 Treatment Team, so care in the community?

12 A. PAUL: Mm hmm.

13 Q. The next in-patient admission that you deal with is 13
14 May 2015, so some months later. That followed an
15 overdose, Beth was detained under section 2 of the Mental
16 Health Act, again admitted to Ardleigh Ward at The Lakes,
17 and also diagnosed with depression and she was identified
18 as a high moderate risk of suicide and self-harm. Then 8
19 June, she was then further detained under section 3 of
20 the Mental Health Act, so for the purposes of ongoing
21 treatment, and discharged 25 July 2016, after which you
22 say in your statement she attended A&E a further five
23 times due to self-harm. So again, just looking at that
24 and you used the words revolving door, we have seen
25 there, even in these early months a number of admissions

1 and discharges?

2 A. ALEX: Yes.

3 Q. And a pattern of presentation to A&E, is that fair to
4 say?

5 A. ALEX: Yes.

6 A. PAUL: Yes, definitely, yes.

7 Q. August 2016, 28 August, she was admitted again as an
8 informal patient to Ardleigh Ward and on 21 October 2016
9 detained under section 3 of the Mental Health Act, then
10 transferred to the Peter Bruff Unit, and then discharged
11 from the Peter Bruff Unit on 12 December 2016. You
12 understand that during that period, Beth both burnt
13 herself and cut herself and the notes show seven visits
14 to A&E in the period between September and October 2016.
15 And as you have referred to a few moments ago, you set
16 out in your statement there, you describe there being a
17 pattern:

18 "Where Beth would be admitted, discharged, and
19 then be bounced back multiple times without, it appeared
20 to us, any apparent oversight of her care or clear
21 treatment or care planning."

22 A. PAUL: Yes. So just on that, can I just come back to
23 your question, Chair? I think this part 5.10 kind of
24 perhaps captures even if Bethany understood what her
25 diagnosis was technically because she had that medical

1 knowledge. I think this, there was no understanding of
2 what the care plan was and what the actions would be that
3 would see her improve.

4 Q. So that deals with 2016. Then moving on into 2017, and
5 just taking you through the chronology of some of the
6 events in that year, the next event is 24 January 2017,
7 Beth had an assessment with a consultant psychologist
8 where she disclosed an intention to take her life by
9 overdose and she also disclosed the existence of a
10 suicide pact with another service user. Now just pausing
11 on that aspect there, that's something you deal with in a
12 bit more detail later in your statement and am I right
13 that was a service user that she knew from The Lakes?

14 A. ALEX: I believe so.

15 A. PAUL: That's my understanding, yes.

16 Q. And she had some sessions with that psychologist, January
17 to March 2017, but you are not sure how helpful that was
18 and you describe her being quite flippant about that
19 care, is that right?

20 A. ALEX: Yes.

21 A. PAUL: Absolutely, yes. I can definitely remember, we
22 shouldn't really be chuckling about it really but there
23 were times when I would literally go and visit her on The
24 Lakes and I would be like, "How are you?", and she would
25 say, "Oh yeah, I'm good, I tried to kill myself today but

1 the nurses helped me so that's good", and she would just
2 say it with this like super flippant, like really it was
3 just matter of fact to her that that was how her days
4 went, and that was normal, it was routine. I think
5 that's what we mean by that sort of flippancy.

6 A. ALEX: Yes.

7 Q. I understand. Then the next admission was 28 March 2017,
8 that was an informal admission to Chelmer Ward in the
9 Derwent Centre following an overdose. She was then
10 discharged eleven days later on 31 March and you comment
11 there that you weren't aware why she was admitted or
12 discharged so quickly, so perhaps another example of that
13 pattern that we have seen of admission and discharge
14 interspersed with self-harm and overdoses. Is that
15 right?

16 A. PAUL: Yes, absolutely.

17 A. ALEX: Yes.

18 Q. And again you describe that as part of, as you put it,
19 the revolving door of admission, discharge and community
20 which appeared to do little to help Beth. One more
21 informal admission in 2017, and then she was managed in
22 the community by the Home Treatment Team and the
23 Specialist Mental Health Team from June to December 2017.
24 You describe that as a period of relative stability. Is
25 that right?

1 A. ALEX: Yes.

2 A. PAUL: Yes.

3 Q. Then 2018 marks a new period, doesn't it? Because 2018
4 marks the beginning of a long admission, a total of eight
5 months, to Ardleigh Ward back at The Lakes, between 22
6 January and 12 August?

7 A. ALEX: Yes.

8 A. PAUL: Yes.

9 A. ALEX: Yes, so you know we are complaining about this
10 quick turn around revolving door kind of system, but then
11 we felt in 2018 she was kept in for an exceptionally long
12 time and then I don't know if it's fair to say that she
13 was never quite the same again since. We describe her as
14 institutionalised by that point. This was when she kind
15 of started to put on the weight, didn't she, because of
16 the medication she was on and things. Yeah, so, like I
17 say we were just complaining about this revolving door
18 and then we get like a longer admission.

19 A. PAUL: But I suppose on that, that's probably why we feel
20 that that overarching care plan was missing because there
21 was the revolving-door approach at one point and then
22 there was a much longer stay, and at no point did it seem
23 like there was a coherent plan that would see her well.

24 THE CHAIR: So nobody explained to you that this might be a
25 planned longer stay. It just -- your evidence is that it

1 just appeared to happen without any coherent, long-term
2 approach?

3 A. ALEX: I mean, us two, personally, were never, obviously,
4 given information directly by any clinicians or anything.
5 So all the news that I ever got was kind of through Beth,
6 and it was always to do with when is the next -- that's
7 kind of what she would report to us, wouldn't she, when
8 we went to visit her, discharges, "They are going to
9 discharge me in seven days" and things like this. It was
10 all very odd. So then again this one I remember her
11 being in there for that long and you would go to visit
12 her and she would go, "I don't know when I am being
13 discharged now." There was always this kind of fixation
14 on it, and I don't know whether that reflects her or
15 whether that reflects the way the health service were
16 communicating her care plan to her. I'm not entirely
17 sure.

18 THE CHAIR: Did she always want to be discharged?

19 A. PAUL: I think most of the time, yes. There's some
20 evidence that will be coming later where we see that
21 change and she actually does sort of try to advocate for
22 herself and unsuccessfully so. And I would just come
23 back to your original question about sort of like the
24 family's involvement. Again, as Alex said, he and I were
25 not directly involved in these kinds of conversations,

1 but our mother was occasionally, again it seems
2 inconsistently, invited so some meetings and not others.
3 But as we will come on to later in some of the later
4 evidence, there was often a theme she wasn't really
5 welcome, she was kind of there to tick a box and she
6 never felt that warmth from those people who were meant
7 to be there to care for Bethany as well. If there was
8 any family engagement, it was like to tick a box rather
9 than to truly engage.

10 THE CHAIR: I think we will be coming back to that.

11 MR COKE-SMYTH: So to summarise, we have gone from a revolving
12 door, short stays of days and weeks with a discharge and
13 then quickly readmitted to what you described here, eight
14 whole months, which is, as you describe, perhaps the
15 opposite end of the spectrum and you have told us that
16 was, in your view, perhaps detrimental and not helpful.
17 It is also right that during that period of admission,
18 your father raised a number of concerns about the care in
19 that period. Now, you deal with those slightly later in
20 your statement, but it seems it might be helpful just to
21 address those now in the chronology because they all
22 relate to that period at The Lakes. So looking further
23 ahead, you address them from paragraph, so page 43, from
24 paragraph 10.1. You describe there the ward environment.

25 A. ALEX: What was the page number again, sorry?

1 Q. 43. And before we go into that, am I right that The
2 Lakes was somewhere you became reasonably familiar with
3 in the course of visits in that period?

4 A. ALEX: Yes.

5 A. PAUL: Of all the wards it was the one I certainly
6 visited the most, yes.

7 A. ALEX: Yes.

8 Q. You note firstly that there wasn't, in your view, much
9 stimulation in the environment?

10 A. ALEX: No.

11 Q. You describe very little by way of activities. Another
12 point you described is not being able to smoke without
13 going on leave. Can you just explain a bit more about
14 that please?

15 A. ALEX: Yes, I find, it's an odd one. So the hospital, I
16 guess quite rightly, has a smoking ban so there's no
17 smoking immediately outside the buildings, or anything
18 like that. But these patients, you know, are kept in a
19 locked facility that has an outdoor area, but they are
20 not allowed to smoke in that outdoor area. So the only
21 way they are able to go outside for a cigarette, which as
22 you will know for someone who is unoccupied and bored all
23 day, we are talking 20 plus a day, they probably want to
24 go, whether or not that they are given the permission to
25 do that is another point, involves them being actually

1 signed out and getting this informal leave to go actually
2 offsite in order just to have a five-minute cigarette
3 break and come back. You described it once, didn't you
4 -- was it you that was saying -- the nurse would come in
5 and be like, "Smoking break time", and everyone would
6 kind of jump up and kind of go off with this nurse and
7 you just think that's barmy. They are in this locked
8 facility with an outdoor space and the bureaucracy to
9 prevent them from being able to partake in that. As a
10 former smoker myself, you know, the stress and extra
11 anxiety, I guess, that that could potentially cause.

12 Q. It's right you also describe other occasions where she
13 actually had to go on leave in order to smoke and that in
14 itself would cause problems because it would expose her
15 to various other pressures which we will come on to.

16 A. ALEX: Yes.

17 A. PAUL: Yes.

18 Q. You also describe Beth being asked what she would do and
19 the response generally being "nothing". And by the
20 sounds of things, it sounds as if it was, for her, quite
21 a boring environment. Is that a fair summary?

22 A. PAUL: Yes, in this paragraph I describe, or we describe,
23 sorry, the news group, which seemed to be the only thing
24 there was in the way of an activity. So it was a bit
25 embarrassing almost to go into the ward because they

1 would have this schedule of like this is what's going on
2 today, these are all the groups, and it was always blank.
3 But the one thing that was consistent was this news
4 group. As I understand it, this was from Bethany's
5 perspective, they got the day's newspapers in and chatted
6 about the news for 30 minutes, and that was it. That was
7 the only structure they appeared to have beyond meal
8 times. There were other options like the gym and things,
9 but again it was always busy, there was always a reason
10 why she couldn't do it. So it's no wonder there was this
11 lack of stimulation on the ward, really, when that was
12 the only thing on offer.

13 Q. And your father was, in fact, so concerned about that
14 period of time he wrote a letter of complaint, and he
15 highlighted a number of things, but that included the
16 fact that Beth continued to self-harm, is that right?

17 A. ALEX: Yes.

18 Q. Also the lack of updates, but he also raised the issue of
19 Beth having had contact with someone who was smuggling
20 drugs on to the ward and the issues that brought. It is
21 right Beth was a drug user and that also brought a degree
22 of risk to her stay as well, and he complained that Beth
23 was also being encouraged to smuggle drugs on to the
24 ward?

25 A. ALEX: Sorry, that then obviously links back to the

1 previous point about these kind of very casual -- they
2 are not discharges.

3 THE CHAIR: Leave.

4 A. ALEX: Yes, periods of leave for her to have a cigarette
5 and potentially bring something into the ward with her.

6 MR COKE-SMYTH: So she is there and she is at Ardleigh Ward,
7 as you said not much to do, lots of periods of leave,
8 leave creating its own risks. Your father identifies
9 some of those. And he also identifies and complains
10 about the fact that, or certainly you refer to the fact
11 that it was this period where Beth entered a suicide pact
12 with another user, is that right?

13 A. PAUL: Yes, that's right.

14 A. ALEX: Yes.

15 Q. So going back then to the chronology, that was Ardleigh
16 Ward on The Lakes, and Beth was, as we have heard, still
17 self-harming and there were still admissions to A&E as a
18 result of self-harm in that period. She was also heard
19 to say that she would kill herself once discharged, that
20 was 12 August, is that right?

21 A. PAUL: Yes, that is right.

22 Q. And then discharged on 13 August 2018 and it's right to
23 say that you were concerned by that discharge?

24 A. PAUL: Yes, and I think it just shows a culture of, I
25 mean it's hard to say a culture when everything is so

1 inconsistent. But it does show a bit of a culture just
2 not taking that suicide risk seriously, and I think in
3 our working lives and our experience and understanding is
4 always like however serious you think it is, it doesn't
5 matter you have to take it seriously. So the fact she
6 was saying she would take her own life and then a day
7 later being discharged was really shocking to us.

8 Q. From your perspective, as a family, was there any clear
9 rationale for discharge on that date as opposed to
10 earlier, or not?

11 A. PAUL: Not from what I remember.

12 A. ALEX: No.

13 Q. Beth was also discharged into the care of your mother.
14 Is that right?

15 A. PAUL: Yes.

16 Q. And you have also expressed concerns about that because
17 your mother, you describe also as having her own
18 difficulties with mental health, is that right?

19 A. PAUL: Yes.

20 A. ALEX: That's correct.

21 Q. And you set out in your statement your concern that in
22 view of that, there ought to have been some sort of
23 assessment or steps taken to make sure that was
24 appropriate, is that fair to say?

25 A. PAUL: Yes.

1 A. ALEX: Yes.

2 Q. And you also describe another aspect of Beth's
3 vulnerability because you say during her time on Ardleigh
4 Ward she was able to take out several payday loans, and
5 that was an additional pressure because it resulted in
6 her being chased for repayment and that became an added
7 stress and pressure in her life. Is that right?

8 A. ALEX: Yes. Is it worth mentioning ... I mean and I
9 believe the reason for the payday loans was to pay for
10 some of these, you know, the drugs that were being
11 smuggled on to the ward. That's my understanding.

12 Q. So in summary, that period hasn't stopped her
13 self-harming, there's an additional concern now about
14 finances and there's also been an ongoing concern about
15 continuing drug use in that period?

16 A. ALEX: Yes.

17 A. PAUL: Yes.

18 Q. So looking then at the next period in the chronology,
19 October -- sorry August 2018 through to October 2018,
20 following discharge, she was initially visited by the
21 home treatment team, that you have described Beth finding
22 that care in the community quite unstructured.

23 A. PAUL: Yes.

24 A. ALEX: Yes.

25 Q. We can see self-harm continued. There was another visit

1 to A&E on 20 August, so that's just eight days after her
2 discharge. Then 29 August care was handed over from the
3 home treatment team to the specialist mental health team,
4 but she kept saying care co-ordinator. Then on 10
5 September 2018 she had a post-discharge appointment
6 following her time on Ardleigh Ward, and she had that
7 with a psychologist who she had also seen during her
8 admission and we see, as you set out there, it was during
9 that appointment that it's recorded that Beth disclosed
10 certain information suggesting that she was subject to
11 serious sexual exploitation?

12 A. ALEX: Yes.

13 A. PAUL: That's right.

14 Q. 14 September 2018, there was a case management
15 appointment with Open Road. Can you tell us what Open
16 Road is?

17 A. PAUL: Yes, so it's an addiction clinic in Clacton on Sea
18 and I think our father, who is a local GP, used to
19 occasionally work there.

20 A. ALEX: Yes, work with them.

21 A. PAUL: So yes, they would advise people who were living
22 with drug addiction.

23 Q. And we see that a cocaine misuse plan was put in place.
24 Can I just ask this, we see reference to cocaine here and
25 elsewhere in your statement. Was that a problem

1 throughout this period, between 2016 and 2018?

2 A. PAUL: Yeah, absolutely, and as Alex mentioned, the
3 payday loans coming and everything, just shows it was
4 really snowballing at this point.

5 Q. And 27 September there was a report of sexual assault by
6 Beth to Essex Police, and then 5 October she attended A&E
7 following an overdose and on 15 October 2018, Beth
8 disclosed that she had been a victim of a financial scam
9 and had lost £100 of her mother's money, and you again
10 comment on that as being an indicator of her
11 vulnerability.

12 A. ALEX: Yes.

13 A. PAUL: Yes, absolutely.

14 Q. The next significant event in this chronology is the very
15 sad and sudden death of your father, Dr John Guille, on
16 28 October 2018 as a result of a stroke. And you
17 describe there, obviously, that was tragic, but you
18 emphasise that that had quite a profound effect on Beth.
19 Can you just tell us a bit more about that, please?

20 A. PAUL: I think I was just saying obviously, we could see
21 that her mental health really deteriorating significantly
22 and the snowballing of the drug addiction and things.
23 But I think really after dad died it kind of felt, yeah,
24 like that's really where things picked up speed, and we
25 will see sort of there's some of the evidence later that

1 shows even like the behaviours around attempts to take
2 her own life and self-harming even changed as well. So
3 yes, it definitely exacerbated everything significantly
4 from that point onwards.

5 Q. And you comment later in the statement but perhaps worth
6 addressing now, that as far as you are aware of what you
7 have seen of the records as well, despite that event,
8 despite its impact, nothing really seemed to change in
9 terms of the care being provided to Beth; is that right?

10 A. PAUL: Yes, there's no evidence that that appears to have
11 taken -- although, like her mentions of dad and missing
12 him and things are in her notes, it doesn't appear like
13 that ever affected care plans, risk assessments, et
14 cetera.

15 Q. Shortly after your father's death we see that, on 1
16 November, she called crisis line, describing wanting to
17 cut her wrists and wanting to be with him, and she then
18 attended A&E having taken an overdose. There was then a
19 medication review on 2 November 2018, and you describe
20 changes to her medication. I'm not going to ask you
21 about the detail of the medication at this point because
22 it involves referring to all the different medication and
23 perhaps easier to deal with that as it is dealt with by
24 the independent report, which was critical of her
25 medication. But perhaps just to summarise at this point.

1 Beth was on a number of different medications, which
2 included those for psychotic symptoms, but you note from
3 the records there is actually no note or medical record
4 of her actually having any psychotic symptoms.

5 A. PAUL: No.

6 Q. You also identify there, and we will come on to this
7 later, the independent report having been critical of
8 Beth being prescribed, not just antipsychotics, but also
9 mood stabilisers, which were prescribed over a period of
10 time, and you refer to the fact that there are NICE
11 guidelines on EUPD.

12 A. PAUL: Yes.

13 Q. And they do not agree with or propose medication in that
14 way for that condition.

15 A. PAUL: Yes.

16 Q. Is that a fair summary at this stage?

17 A. ALEX: Yes.

18 A. PAUL: That's perfect, yes.

19 A. ALEX: And at the inquest under questioning there was
20 clinician, I think one, but the clinician who was
21 questioned about this near enough like dismissed the
22 NICE -- not dismissed, that's obviously extreme, I don't
23 mean that at all. But said, you know, said, "Sometimes
24 we don't follow the NICE guidelines essentially", words
25 to that effect and didn't really explain to the coroner.

1 The Coroner didn't appear to be very happy with that as
2 an explanation for it.

3 Q. Just going back to the introduction one of your
4 criticisms of the medication was again the focus on
5 addressing symptoms rather than actually dealing with the
6 underlying treatment and problem. Is that right?

7 A. ALEX: Yes.

8 A. PAUL: Yeah, definitely, I think from what we can see as
9 you will see, we go through this statement, there's
10 almost like discharge and this is the updated medication
11 list and then this happened and here's the updated
12 medication list. It almost felt like they were almost
13 just bandaging, papering over cracks, and then hoping to
14 move on with, again, no real overarching strategy or
15 plan.

16 Q. And we come now to the period between November 2018 up to
17 January 2019 and it is fair to say that this is a period
18 of lots of admissions?

19 A. ALEX: Yes.

20 Q. Relatively short stays, discharge, further self-harm,
21 further admissions, further discharge. So not dissimilar
22 to the first period we looked at, but as we can see from
23 the statement and what happened, escalating risks and
24 behaviours on Beth's part. Is that right?

25 A. PAUL: Yes, absolutely.

1 Q. So moving to the next admission, that was 13 November, or
2 13 to 15 November 2018. Beth was admitted as an informal
3 patient to the Peter Bruff unit. That was following an
4 admission to A&E. Whilst she was there as an informal
5 patient she attempted to self-asphyxiate. She was also
6 reviewed by a consultant psychiatrist and it was noted
7 that her mental health had deteriorated significantly,
8 and that she was displaying near constant suicidal
9 thoughts. We can see it was noted she was on level 3
10 observations, it was noted that she was using cocaine in
11 the community and it was noted that she wasn't able to
12 keep safe outside of the ward environment. And indeed,
13 from your evidence that's consistent with your experience
14 as well?

15 A. ALEX: Yes.

16 A. PAUL: Yes.

17 Q. As a result, she was detained under section 3 and she was
18 then transferred to Thorpe Ward, where she was between 15
19 and 22 November, and she described telling clinicians
20 there about having seen her father at rest, finding that
21 very distressing and she's also reported to have spoken
22 about her cocaine use. She was initially assessed as
23 being high risk in relation to suicide, she was under
24 level 3 observations. Then looking at your paragraph
25 5.46, we see 19 November 2018 her detention under section

1 3 was rescinded. And you make the comment there that
2 there was no clear rationale for that decision at the
3 time, and, again, is that consistent with your
4 experiences previously?

5 A. PAUL: Yeah, absolutely and I just think this, as you'll
6 see throughout, really from this period through to
7 January, this November to January period, the mix of
8 sections and informal admissions, again, just really is
9 completely incoherent. Some of the really, and also
10 observation levels as well. Sometimes the really high
11 risk behaviours she would demonstrate would result in
12 level 2, level 3 observation, and then you find out that
13 a few hours later she is being let out on leave.
14 Similarly with sections and informal admissions, I think
15 one would reasonably assume that as the sections get
16 used, that's becoming more severe and there's a reason
17 behind it. But it just very much felt random, like,
18 yeah, in many ways we were quite lucky that she did
19 advocate for herself and admit herself sometimes really
20 because it doesn't seem like the sections were really
21 used to help her, I suppose.

22 Q. And in fact, looking at this decision, you note there in
23 your statement, having reviewed the case notes from 19
24 November and that decision, they don't include any
25 rationale or justification for that decision, and you

1 describe there that you were later told -- and am I right
2 was this in the course of the inquest process that you
3 were later given an explanation?

4 A. PAUL: Sorry, an explanation?

5 Q. Of the decision to discharge?

6 A. PAUL: Yes, I suppose "explanation" is an interesting
7 word to use, but I suppose that's where we then found,
8 saw the documentation and, yeah, started to work out what
9 was going on.

10 Q. Sorry my fault, I perhaps wasn't clear, when I say
11 "explanation", explanation from the treating psychiatrist
12 who explained at the inquest?

13

14 A. PAUL: Yes, yes, yes, sorry.

15 Q. So you have described there wasn't anything in the notes
16 but you then heard their explanation. Is that right?

17 A. ALEX: Yes. So in the inquest that would be part that
18 the Coroner, you know, got out of the clinicians because
19 he went through, obviously, this. You will see, the
20 events really ramp up at this stage, so he really went
21 through this bit in detail.

22 Q. That explanation included that there was no formal
23 thought disorder and no active plans by Beth to kill
24 herself, so that was the explanation given at the
25 inquest. Is that right?

1 A. PAUL: Yes.

2 Q. It is also right that here it was planned and here we see
3 the start of what becomes a pattern, the planning a
4 discharge date, and we see this from November through to
5 January. So here on the 19th it was planned for Beth to
6 be discharged on the 22nd.

7 A. ALEX: Yes, yes and this appears to be now like kind of
8 formalised. But like we mentioned before, this fixation
9 on when I'm being discharged, when I'm getting out, you
10 know, was kind of present for a lot of the time, I think
11 that's fair to say, isn't it, even in the time leading
12 up.

13 Q. You, in fact, highlight, so you heard evidence that said
14 there was no intention by Beth to kill herself, there was
15 no record on the day. But, in fact, you highlight if we
16 just move forward to a later record, 5.52, during a later
17 assessment on the Thorpe Ward, we can see that there's a
18 record, in fact, of Beth herself explaining her
19 perspective, and I'm just going to read this out because
20 this comes from a clinical record, doesn't it?

21 A. PAUL: Yes.

22 A. ALEX: Yes.

23 Q. It says there:

24 "She was not happy when she was told that she
25 was big discharged from Thorpe Ward as she did not feel

1 that she was ready for discharge."

2 She states that:

3 "She expressed her concerns and her continued
4 suicidal ideation to staff on the ward. But she feels
5 this was not taken seriously."

6 So not consistent, we can see the record there
7 from what you were told at the inquest?

8 A. PAUL: It might also be worth noting that that is again a
9 change in behaviour as well, where she is starting to
10 advocate for herself and actually perhaps knew herself
11 she wasn't safe as well through some of these actions
12 that we will see.

13 Q. So the start of a period, and we are going to see more of
14 this pattern of Beth being told she is going to be
15 discharged in advance, her not feeling particularly happy
16 with that, and then being discharged relatively quickly in
17 accordance with that plan.

18 A. ALEX: Yes.

19 A. PAUL: Yes.

20 A. ALEX: Or being told, you know, that you have got this
21 discharge date coming up and then taking other actions,
22 you know, like these suicide attempts and/or self-harming
23 potentially.

24 Q. We can see that in accordance with the plan made on the
25 19th, Beth was indeed discharged on the 22nd and you

1 express your strong concern, I am looking at your
2 paragraph 5.49, with that decision to discharge her on
3 this occasion. You describe that as an "unbelievable
4 action", and you say there from your perspective:

5 "The Mental Health Team showed little
6 understanding or insight into the way that Beth was
7 failing to cope with our father's death."

8 And you describe she was subsequently
9 readmitted very quickly after your father's funeral and
10 as we are about to hear, in the next four months,
11 following your father's death and Beth's death, she was
12 admitted as an in-patient to Basildon a further four
13 times?

14 A. PAUL: Yes.

15 Q. So the next admission, 24 November 2018, that was an
16 admission for just four days, 24 to 28 November, so we
17 can see there that she has in fact been readmitted two
18 days after her discharge. 24 November is the day after
19 your father's funeral?

20 A. PAUL: Mm hmm.

21 Q. And you describe how Beth seemed to you when you saw her
22 at your father's funeral so on this day between these
23 admissions, 23 November, and you describe her as
24 "zombified" in your words, is that right?

25 A. PAUL: Yes, definitely this was the -- I think Alex

1 touched on it briefly earlier but I think it was far
2 worse at this point. We assume it was medication but,
3 yes, she was very slow and sluggish, we always knew her
4 as quite a bouncy, happy go lucky kind of person and she
5 definitely wasn't at this point. Her speech was often
6 slurred and she would sort of sit with her mouth open and
7 things like that. So she just seemed completely -- yeah,
8 for want of a better phrase, just completely drugged up,
9 I suppose.

10 Q. And you describe the side effects from medication
11 becoming more pronounced in the months leading up to her
12 death?

13 A. PAUL: Mm hmm.

14 A. ALEX: Yes.

15 Q. And you express in your statement your concern at how
16 what you saw, by way of what you have just described,
17 didn't seem to actually prompt any review or change to
18 Beth's medication?

19 A. PAUL: Yes, that's right.

20 A. ALEX: Yes.

21 Q. So admitted on 24 November, discharged four days later
22 this time, second time in a month, on 28 November 2018.
23 And in your words, I am looking at paragraph 5.53:

24 "There appeared to be no longitudinal
25 assessment of the impact of our father's death, Beth's

1 vulnerabilities, coping mechanisms and co-occurring
2 conditions."

3 Can I enquire what you mean by co-occurring
4 conditions, are you also referring there to her cocaine
5 use?

6 A. PAUL: Yes.

7 A. ALEX: Yes.

8 Q. Moving forward then into December 2018 and looking at
9 your paragraph 5.55, Beth was discharged from the Dual
10 Diagnosis Team back into the care of the SMHT, Specialist
11 Mental Health Team. And you say you have not been able
12 to establish any clear reasoning for that. Just pausing
13 there, the Dual Diagnosis Team, is that a team
14 responsible for dealing with those with comorbidity, so
15 for example not just EUPD, but also things like
16 addiction?

17 A. PAUL: Yes, my understanding was it was the addiction was
18 the main reason why she was under the DDT.

19 A. ALEX: Yes.

20 Q. And as far as the family was concerned, am I right that
21 Dual Diagnosis therefore would have been the appropriate
22 team, in your view, to continue her care?

23 A. PAUL: Definitely.

24 A. ALEX: Yes.

25 Q. And that remained the case given, as you have described,

1 her continuing cocaine use?

2 A. PAUL: Yes.

3 A. ALEX: Yes.

4 Q. Then between 1 and 7 December, a number of further
5 worrying incidents. Just to summarise, 1 December Beth
6 was admitted to A&E after hitting her head on a stone
7 object. On 3 December she visited a community practice
8 nurse from the Home Treatment Team, she disclosed she had
9 been sexually assaulted and on 6 December she called the
10 crisis team disclosing an overdose and having cut her
11 wrists and that led to 2 days in A&E before she
12 discharged herself. The next admission began on 10
13 December 2018 to the Peter Bruff Unit. That was as a
14 result of further self-harm, and right that from your
15 review of the in-patient records, there are a number of
16 further instances of self-harm in that period. They also
17 record cocaine use and they also record an instance of
18 ligaturing.

19 A. PAUL: Mm hmm.

20 Q. We then come to 11 December, where she was reviewed by a
21 consultant psychiatrist and that psychiatrist noted, as
22 you have set out, that her mental health had deteriorated
23 since her discharge from Thorpe Ward?

24 A. PAUL: Mm hmm.

25 Q. Does that, is that consistent with your experiences at

1 the time?

2 A. PAUL: Yes.

3 A. ALEX: Yes.

4 A. PAUL: I think Thorpe, it's probably not fair to rank
5 them, but I think certainly like when she came back from
6 Thorpe Ward, often felt like that was when she was at her
7 worst, and then later on in part 2 we will talk about
8 ward environment and things so ...

9 Q. And we see reference there to that psychiatrist also
10 giving a statement later to the inquest in which it was
11 said that staff had been asked to raise safeguarding with
12 the safeguarding team at the trust, but right that as a
13 matter of fact at no point during Beth's care was a
14 safeguarding referral, in fact, ever made by the trust,
15 is that right?

16 A. PAUL: Yes, that's our understanding, yes.

17 A. ALEX: Yes.

18 Q. 5.62, 12 December there was a further report of Beth
19 disclosing being sexually exploited, and here we can see
20 that in fact a safeguarding form was completed but it was
21 never sent.

22 A. PAUL: Mm hmm.

23 A. ALEX: It appears so, yes.

24 Q. And as you set out there it was never sent to the trust
25 safeguarding team, it was also never sent to Essex County

1 Council and you explain the result of that was that there
2 was no monitoring or further action about those types of
3 concern?

4 A. PAUL: Yes, absolutely and again when we have got a
5 situation where lots of change is happening over a short
6 period of time, I think you would expect to see that
7 reflected in risk assessments, care plans, et cetera and
8 there's just no evidence of that that we've seen.

9 Q. And that issue of sexual exploitation, it's not one that
10 changes or goes away in that period?

11 A. ALEX: Mm hmm.

12 A. PAUL: Absolutely.

13 Q. 15 December 2018, Beth left the ward on leave and it's
14 recorded there that she had rung to say she was feeling
15 suicidal, she came back to the ward and staff responded
16 to a call bell to find that Beth had tied a ligature
17 around her neck, and again she disclosed to staff on that
18 occasion that she was terrified of a man who was
19 exploiting her.

20 A. PAUL: Yes.

21 Q. 17 December, she returned to the ward from leave and she
22 was in possession of blades which were removed. And on
23 18 December she was reviewed by the same psychiatrist you
24 have described earlier who saw her on the 11th and had
25 earlier noted the deterioration since leaving Thorpe

1 Ward, is that right?

2 A. ALEX: Yes.

3 A. PAUL: Yes.

4 Q. And then we see here on that date, on the 18th that that
5 psychiatrist decided to discharge Beth. They didn't
6 consider any benefit detaining her under section, and you
7 note that on the ward review prior to discharge, there's
8 a record of Beth continuing to use cocaine on leave and
9 that she thought her symptoms were severe. So this would
10 be the third discharge following your father's death?

11 A. ALEX: Yes.

12 A. PAUL: And a discharge a day after she had been found
13 with blades in her possession as well so ...

14 Q. And again you detail there that the family had very
15 serious concerns about the rationale and decision-making
16 given that behaviour and history which we have just been
17 through?

18 A. PAUL: Yes.

19 Q. The next period, so discharged on 18 December and then
20 twelve days later on 30 December, readmitted and again to
21 the Peter Bruff Unit for a period between 30 December and
22 3 January, and that was the result of having attended
23 A&E, having been brought in by a friend following threats
24 to drown herself. Again, not under section, but admitted
25 as an informal patient. She disclosed again having been

1 contacting the man -- or contact with the man, I should
2 say, who she had previously said had been exploiting her.
3 Then 31 December, the day after her admission, looking at
4 your paragraph 5.68, a plan was made to discharge Beth on
5 3 January, is that right?

6 A. PAUL: Yes.

7 A. ALEX: Yes.

8 Q. So we will deal with that decision later, but right to
9 say, as you refer to there, you were concerned about
10 that, that was also a decision which was subject to
11 criticism at the later inquest, is that right?

12 A. ALEX: Yes.

13 Q. And that criticism included there being a lack of
14 community care planning for Beth on her discharge?

15 A. ALEX: Yes.

16 A. PAUL: Yes.

17 Q. It's right that then in the period, so the plan is made
18 on 31 December to discharge Beth on 3 January, but also
19 important to make clear that there were certainly two
20 very significant events that took place after that plan
21 was made, and before I go into the detail, it is worth
22 establishing that you as a family were not made aware of
23 either of these events at the time. Is that right?

24 A. PAUL: Yes, certainly not the severity of them either as
25 well, so yeah.

1 Q. Now, I am going to in fact ask and I am going to read the
2 detail of this first event because there is some detail
3 in it, and I am going to ask that this be put up on
4 screen because this is a record of what was recorded in
5 the case notes about an incident which happened the day
6 after the decision was made, or the plan was made to
7 discharge Beth and this is a record from 1 January 2019.
8 It is page 25, paragraph 5.74:

9 "Beth found on the floor on the side of the
10 bed close to the adjacent wall with tight ligature in
11 place round patient neck at around 0030. Beth was
12 visibly purple and had burst blood vessels in her face.
13 Ligature cut. Beth sustained minimal scratches to the
14 back of her neck as a result. Beth was placed on
15 enhanced observation level 2 4/60" -- describes physical
16 observations obtained -- "Ambulance called due to a
17 laboured breathing. Beth was only responding to loud
18 talking, was not responsive to touch or pain when
19 ambulance team arrived. Oxygen was given with a
20 rebreathing mask although this proved only slightly
21 effective ... Patient was taken to CGH A&E ... once in
22 A&E Beth was taken to Majors where they requested a
23 neck/head scan and a chest x-ray."

24 So that's the first incident, on 1 January, and
25 that's what's record from the notes at the time. Again,

1 you weren't aware of this as a family?

2 A. PAUL: No.

3 Q. Second incident, now there is perhaps some confusion over
4 the exact date or time of this because of the records but
5 it is referred to as taking place on 2 January.

6 Whichever way, it was closely in time after the incident
7 on 1 January. Again, I am going to ask that we put up on
8 screen what is recorded in the notes about that incident.
9 It's page 26, paragraph 5.77. The case notes record as
10 follows:

11 "Later on in the shift the bathroom buzzer was
12 called. On arrival the door was blocked and could only
13 open a short way. Beth was moved from the door and was
14 found with a ligature in place. Beth was a deep purple
15 shade and her legs were shaking. The ligature was cut
16 off with difficulty as it was very tight and hard to get
17 the cutters in-between. Beth also had put (an item) in
18 her mouth which was visible and easily removed.
19 Observations were taken and all within range ... It was
20 explained to Beth that show would now be placed on level
21 3 observations as her safety could not be managed on
22 level 2."

23 So that's the record of the second incident,
24 again not one which you as a family were made aware of at
25 the time. Is that right?

1 A. PAUL: That's right.

2 A. ALEX: That's correct.

3 Q. It's also right to say that there was a record, a
4 clinical record that you describe in your statement which
5 was made between those two instances and in fact
6 described Beth as "bright and settled", but you express
7 your surprise at that, given those two records I have
8 just read.

9 A. ALEX: Yes.

10 A. PAUL: Yes, absolutely.

11 Q. Now, you then deal with a thing called the DATIX, which
12 is a document or record kept by the trust of incidents
13 and it's right that the DATIX record in respect of
14 incidents concerning Beth was provided to you during the
15 course of the inquest?

16 A. PAUL: Yes.

17 Q. And you were able to see that these two incidents which I
18 have just read out were categorised within that DATIX.
19 Is that right?

20 A. ALEX: Yes.

21 Q. And the category or the way in which they were reported
22 or characterised in that DATIX reporting system was as
23 and I am going to quote the words "not serious
24 incidents".

25 A. ALEX: Yes.

1 Q. And they were also recorded as "low harm" for the first
2 incident and "no harm" for the second incident?

3 A. ALEX: Yes.

4 Q. And perhaps unsurprisingly you express your concern at
5 that classification?

6 A. ALEX: Yes.

7 A. PAUL: Yes, I think, as it's in our 5.76, it's hard to
8 see that anybody who was administered a breathing mask
9 could possibly be regarded as low harm.

10 Q. And it's also right that the independent investigation
11 report concluded, again perhaps not surprisingly, that
12 those should have been recorded in fact as near misses,
13 and the near miss being near miss of death or very
14 serious injury?

15 A. PAUL: Mm hmm, yes.

16 A. ALEX: Yes.

17 Q. And the result of that is you express your broader
18 concern at the accuracy of DATIX reporting amongst the
19 Essex trusts?

20 A. ALEX: Yes, and under the, again at the inquest, at the
21 inquest the Coroner did get clinicians to, at least one
22 clinician, to admit that that was a near miss as well.
23 So yes, clinicians have confirmed that those cases should
24 have been recorded that way.

25 A. PAUL: It is also just worth drawing attention to our

1 5.82 as well, where it does seem like this is not
2 exclusive to our case as well.

3 A. ALEX: Yes.

4 Q. Thank you. Now coming back then, if I may, to the
5 discharge decision. So to recap, that was made on 31
6 December?

7 A. PAUL: Mm hmm.

8 Q. Those two incidents then happen and as a matter of fact
9 there was no change to the plan which had been to
10 discharge Beth on 3 January?

11 A. ALEX: Yes.

12 Q. So as far as you could see, those incidents didn't have
13 any effect on that plan?

14 A. PAUL: No, it's absolutely baffling to go from a day
15 after a near miss to being discharged, yes. It's hard to
16 see where that could happen and those near misses could
17 reasonably be taken into consideration about her care.

18 Q. And she was discharged to your mother?

19 A. PAUL: Mm hmm.

20 Q. And you have told us you weren't aware or the family
21 weren't aware, but just to make absolutely clear, your
22 mother also wasn't made aware of those two incidents when
23 Beth was discharged?

24 A. PAUL: Yes, that's right.

25 Q. And you point out in your statement that the

1 justification for Beth's discharge by the psychiatrist
2 who made the decision on 31 December was that Beth had no
3 active suicidal intention, psychosis or depression and
4 you point out that that assessment doesn't appear to take
5 account of those two incidents I have just read.

6 A. ALEX: Clearly, yes.

7 Q. Now, the next stage is a period between 5 and 9 January
8 where Beth continued to live with your mother and you
9 highlight there some of the challenges around that and
10 difficulties given your own mother's health. And then 5
11 January Beth contacted crisis line reporting she was
12 suicidal, 7 January she attended an appointment with Open
13 Road regarding substance misuse and according to the
14 records there, Beth appeared concerned at her discharge,
15 having said this had been "despite", and that being her
16 word, an attempted suicide attempt. Is that right?

17 A. PAUL: Yeah, I think again this just shows, as was seen
18 previously, it's a change in how she was starting to feel
19 about her care and I mentioned that it feels like she
20 started to feel unsafe. I think this is a good example
21 of where that was the case.

22 Q. Then 8 January, attended A&E again and then we come on to
23 the final period of admission, where she was admitted 9
24 January to the Peter Bruff Assessment Unit as an informal
25 patient. As you have commented, this would be her fourth

1 admission since November?

2 A. PAUL: Yes.

3 A. ALEX: Yes.

4 Q. I am conscious of the time. I might try and continue to
5 see if we can deal with this incident now before the
6 break, if I may? I may go slightly over half-past.

7 A. ALEX: Absolutely fine.

8 A. PAUL: That's okay.

9 Q. So you say there admitted, placed on level 2
10 observations, and then 10 January she was assessed by a
11 consultant psychiatrist. It was noted again that Beth
12 continued to feel suicidal with constant ruminating
13 thoughts asking her to kill herself. 11 January, there
14 was a review and she was deemed a high risk of suicide,
15 and it was also reported that Beth wanted to stay on the
16 ward because she felt safe. Detention under section was
17 considered but the treating psychiatrist decided against
18 it and she remained an informal patient. Just to be
19 clear, because she was an informal patient that meant
20 that she could come and go as she wished. Is that right?

21 A. PAUL: Yes.

22 A. ALEX: Yes, and actually in the previous paragraph 5.89,
23 it shows that she self-ligatured for a third time there
24 as well.

25 Q. So again no real change in that level of risk. So 11

1 January, no consideration of detention under section,
2 however, there was then a further incident on 11 January
3 which appears to have taken place after this assessment
4 and you deal with that at 5.94. You express there your
5 concerns and surprise that she was in fact given leave,
6 given the ongoing concerns about sexual exploitation?

7 A. PAUL: Mm hmm.

8 Q. And you describe there that during leave Beth met a man
9 who she had previously said or had said to have been
10 sexually exploiting her and she returned to the unit at
11 7.15 visibly upset, no trousers and reported having been
12 sexually assaulted to police.

13 A. PAUL: Yes.

14 Q. 12 January, then seen again by the same psychiatrist who
15 had seen her on the 11th. And it's right just to
16 summarise that although there was no change to her status
17 as an informal patient, so there wasn't any further
18 assessment under the Mental Health Act, and she wasn't
19 formally detained, it is right that that psychiatrist
20 later accepted that the incident I have just described
21 and Beth returning home, or returning back to the unit,
22 should have prompted a review under the Mental Health
23 Act?

24 A. ALEX: Mm hmm.

25 A. PAUL: Yes.

1 Q. This time Beth's mother was informed of the reported
2 sexual assault, and then 13 January Beth was interviewed
3 by police about events the previous day, and 14 January
4 she went on leave, this time with a support worker from
5 Reed, but on return she cut the crook of her arm and she
6 admitted to having concealed a blade on her person. She
7 was then placed on level 3 observations. 15 January,
8 there was an MDT meeting, staff were told about the
9 police investigation in respect of Beth's allegations and
10 she also admitted taking £200 worth of cocaine a week.

11 A. ALEX: Yes.

12 Q. So that's the immediate run-up to the final event I am
13 going to deal with in the chronology and that's Beth's
14 transfer to Thorpe Ward?

15 A. PAUL: Is it okay to just really quickly, just on the
16 paragraph 5.99, that incident with Bethany cutting the
17 crook of her arm was, I think, treated by the coroner
18 certainly as like another very near miss and also
19 demonstrates that behaviour change because again, as I
20 understand it, I don't think she called for help on that
21 occasion either.

22 Q. So just to be --

23 A. PAUL: That's 5.99. Sorry, to bring you back but.

24 Q. No, and that's in respect of the use of the razor blade.

25 THE CHAIR: Blade.

1 A. PAUL: Blade, yes.

2 MR COKE-SMYTH: So transfer then to Thorpe Ward that was
3 arranged because of a shortage of beds on the Peter Bruff
4 Unit and it was arranged using a company called Delta
5 Medical Services, a private patient transfer service, and
6 I am going to summarise these aspects. It is right to
7 say that there is a very detailed set of findings in the
8 jury's narrative conclusion and they are also in respect
9 of this day admissions by the trust as to two key
10 failings.

11 A. PAUL: Yes.

12 Q. Beth wasn't accompanied by any paperwork and she was also
13 not accompanied by any staff from Peter Bruff Ward. You
14 express your surprise at that, given that to your
15 knowledge there were no shortages of staff on Peter Bruff
16 Ward. And your account, you summarise then the evidence
17 heard at the inquest which you attended and which again
18 is reflected in the conclusion. So I am just going to go
19 through that, if I may. There was a verbal handover from
20 Peter Bruff staff to Delta staff but no risk issues were
21 reported. It was admitted by EPUT at the inquest that
22 staff should have accompanied Beth and there should have
23 been a handover, is that right?

24 A. ALEX: Yes.

25 A. PAUL: Yes.

1 Q. Evidence was heard that Thorpe Ward was not given prior
2 notice of the transfer?

3 A. PAUL: Yes.

4 Q. That meant that they were reliant purely on medical
5 records. However, the two wards were using two different
6 types of patient record software which meant that Thorpe
7 Ward couldn't check or see Beth's recent history?

8 A. ALEX: That's correct.

9 Q. Even though there was no handover Beth is recorded as
10 having disclosed, on her admission to Thorpe Ward, her
11 previous self-harm and ligaturing, as well as previous
12 sexual exploitation and her plan to kill herself. She
13 was assessed as high risk of suicide and self-harm and
14 she was initially placed on level 2 observations, that
15 being a reduction from level 3 at Peter Bruff, and she
16 was placed on a female dormitory. Your mother reported
17 being able to speak to Beth on the phone and being told
18 that she had already been given a discharge date of 22
19 January. Is that right?

20 A. PAUL: Yes.

21 Q. And again, you express a similar concern, given her
22 self-harm and the evidence you have given about that.
23 Then 16 January she was granted a period of leave in the
24 morning and it's recorded that around 12.30 pm, so
25 presumably after her return, her observations were

1 reduced to level 1. You understood that the
2 justification for that from the admitting psychiatrist
3 was on the basis that she had gone on leave without any
4 issues?

5 A. ALEX: Yes.

6 A. PAUL: Yes.

7 Q. Again that decision is one which you cannot understand
8 and is a significant concern, is that a fair summary?

9 A. PAUL: Yes, absolutely. Again, that just sort of
10 inconsistency of when leave is allowed, when your
11 observations levels, et cetera, it just seems completely
12 random, again.

13 A. ALEX: Yes.

14 Q. The next time in the chronology at 7.43 in the evening,
15 Beth was found with a white scarf tied around her neck.
16 Attempts to resuscitate her were unsuccessful and sadly
17 she had died. You raise the family's concern again that
18 she had access to a scarf given her risk of suicide.

19 A. ALEX: Yes.

20 Q. And it's also right that during the inquest it emerged
21 that the nurse responsible for Beth's final observations,
22 which would have been or ought to have been sometime
23 around 7, had not made a contemporaneous record and had
24 been called back later after Beth's death to complete
25 that observation.

1 A. ALEX: Yes.

2 Q. So that deals with the chronology. I think, Chair, that
3 may be an appropriate moment for a break, I am sorry I
4 have gone a bit beyond 11.30.

5 THE CHAIR: That's fine, thank you very much. How long would
6 you like us to break for?

7 MR COKE-SMYTH: Could we resume please at 11.50?

8 THE CHAIR: 11.50? Thank you.

9 (11.36 am)

10 (Break)

11 (11.53 am)

12 MR COKE-SMYTH: Chair, thank you. I want to now move on to
13 the second part of your statement, where you deal with
14 some of the themes and issues in respect of Beth's care
15 and subsequent investigations. Before I do that, there
16 are just two brief factual matters I want to just
17 highlight in respect of safeguarding. You have given
18 evidence about safeguarding and some of the issues that
19 were disclosed by Beth to various health professionals.
20 But it's also right, isn't it, that by way of background,
21 and I take this from 4.8, page 5 of your statement, Beth
22 had had a series of abusive and traumatising
23 relationships with older men from a young age.

24 A. ALEX: Yes.

25 Q. And it's also right that as a result your father, John,

1 had previously taken out a restraining order against one
2 of those men.

3 A. PAUL: Yes.

4 Q. And she had also suffered domestic violence in these
5 relationships.

6 A. ALEX: Yes.

7 A. PAUL: That's correct.

8 Q. That is the foundation upon which we can look at the
9 subsequent concerns during her admission which you have
10 given evidence about before the break.

11 A. ALEX: Mm hmm.

12 Q. One other date to highlight, also relevant to
13 safeguarding and this is page 23, your paragraph 5.65, on
14 17 December 2018, this was the date when Beth returned to
15 the ward at the Peter Bruff unit, and was found in
16 possession of blades. You also subsequently discovered
17 at the inquest that also on that day she had contacted
18 police herself to say that she was at risk of being
19 trafficked?

20 A. ALEX: Yes.

21 A. PAUL: Yes.

22 Q. So picking up the second part of your statement, the
23 first topic that you deal with is diagnosis, and this is
24 in fact the topic or the area which I started with, if
25 you will recall, at the beginning of your evidence, where

1 I took you to the relevant part from the independent
2 investigation report into Beth's care. You set out there
3 in your statement that in the last three years of her
4 life, Beth's mental health significantly deteriorated,
5 despite all of those admissions and discharges that we
6 have seen, and in your words that was a revolving door of
7 admission and discharge.

8 A. PAUL: Yes.

9 A. ALEX: Yes.

10 Q. We can see from the chronology that the change or the
11 deterioration after your father's death in October 2018,
12 but you also note there the very serious near misses on 1
13 and 2 January on the Peter Bruff unit. As I read out at
14 the beginning, the conclusion of the independent report
15 really was that there was no holistic approach to Beth's
16 care, and it also concluded, as I read out earlier, that
17 the lack of robust diagnostic formulation was the most
18 probable cause for failure of all subsequent care and
19 treatment interventions. You set out, so the diagnosis
20 we know in Beth's case was EUPD and you identify that
21 even, or despite the issues in respect of her care, there
22 is, so far as you are aware, still no pathway to deal
23 with that condition and that is an ongoing concern for
24 you and presumably the family.

25 A. ALEX: Yes.

1 A. PAUL: Yeah, you will see that my sister -- my sister,
2 Sarah, and mother were actually involved in a working
3 group set up like a -- to sort of inform a pathway for
4 patients with diagnoses of EUPD, which was outlined in
5 7.6. So it's obviously something that has concerned our
6 family for a while, and it's devastating to know that
7 despite that, there doesn't seem to have been anything in
8 place by the time that Bethany was unwell.

9 Q. Linked to the question of diagnosis are the concerns
10 around Beth's medication and you set that out at 7.7 and
11 7.8. This is an area which was addressed in the
12 independent report and that report says this:

13 "It would appear that the medical response to
14 Beth's EUPD was managed poorly over a period of years.
15 This method was neither effective nor entirely safe on
16 multiple fronts. Whilst a combination approach,
17 medication with psychological therapy inputs was
18 indicated, Beth's medication regime appears to have been
19 difficult to justify at times and went against best
20 practice guidance. A omission was that detailed
21 symptomology were not identified prior to medication
22 regimens being developed. This means that clinicians did
23 not have a recorded plan with regard to the symptoms they
24 hoped the medication would effect. This indicated that
25 medication reviews might not have been as effective as

1 they needed to be and at times caused Miss A" -- or Beth
2 I should say -- "to experience significant side effects
3 and oversedation."

4 A. ALEX: Yes.

5 A. PAUL: Yes.

6 Q. You wholeheartedly agree with that conclusion, is that
7 right?

8 A. ALEX: Yes.

9 A. PAUL: Yes, we mentioned earlier that oversedation
10 element, where we noticed things like slurred speech and
11 yeah, just not the same Bethany that we sort of knew and
12 grew up with. And just to sort of build on 7.7 and 7.8,
13 if you don't mind, I think it just felt often when we
14 look through the notes, it feels very reactive some of
15 these medication reviews. So the independent report
16 obviously outlines that there were failures in terms of
17 the medication. But even as someone who has zero medical
18 background, it did seem very much like this happened, so
19 they gave her these drugs and it's not always clear what
20 the thinking was and the independent report did a
21 particularly good job of really highlighting that as
22 well.

23 THE CHAIR: You refer to the emphasis on simply treating
24 Beth's physical symptoms. What were her physical
25 symptoms?

1 A. PAUL: I can't list them all, but I know, for example, at
2 point she was on -- was it blood pressure medication at
3 one point as well? That's a point that we may come to
4 later in terms of how EPUT responded. But yes, there
5 were some things like that that were thrown in and yes,
6 there were points I think, as we have mentioned in our
7 earlier evidence, there was a point when she was taking
8 antipsychotic medication when there was no evidence of
9 any --

10 THE CHAIR: Psychosis.

11 A. PAUL: Yes.

12 THE CHAIR: Thank you.

13 MR COKE-SMYTH: You say there was no effort to try and
14 understand her triggers and protective factors, so that
15 she could keep herself safe, so that her mental health
16 could improve.

17 A. ALEX: Yes.

18 Q. It's also right, as we will come on to, that this
19 question of medication also perhaps links to care and
20 treatment planning because you deal with that under a
21 separate heading, but in fact you say similar things
22 about that in terms of a lack of holistic or co-ordinated
23 plan.

24 A. ALEX: Correct, yes.

25 Q. Dealing then with assessment, you don't seek to identify

1 a time where Beth wasn't admitted, but you think she
2 should have been. But you do, and we have seen some of
3 these instances in the chronology, you have expressed
4 serious concerns about decisions to discharge Beth and
5 particularly about the lack of consistency in that care
6 and treatment. You used the words:

7 "It was all lurching around from crisis
8 management without proper consideration of the particular
9 circumstances, her comorbidities being substance misuse
10 and how it was managed."

11 You also there identify what we have been
12 through in detail, the shift in approach to discharge
13 date and in your view the pressure that created on Beth.

14 A. PAUL: Yes.

15 Q. You also highlight the near misses of the 1 and 2
16 January, where despite the situation changing, most
17 obviously there the plan stayed the same. You also agree
18 again with the conclusions of the independent report,
19 which says that:

20 "It's extraordinary to see that during Beth's
21 last few weeks that despite two extremely serious self-
ligature
22 events - both of which could have caused her death, no
23 in-depth risk assessment was taken or management plan put
24 in place. It would appear that services had developed a
25 very high tolerance threshold when dealing with Beth's

1 behaviours at this time and that discharge was imminent
2 days before her death. It was entirely predictable that
3 Beth would continue to escalate her behaviours and it was
4 evident that she was highly distressed and totally out of
5 control."

6 And the report goes on to say that those two
7 serious attempts at self-strangulation should have led to
8 an assessment of Beth's status under the Mental Health
9 Act, and right that that would have been given the option
10 of detaining her, rather than her remaining an informal
11 and voluntary patient who could come and go and leave as
12 she wished, is that right?

13 A. ALEX: Yes.

14 A. PAUL: That's right.

15 Q. And it says that:

16 "Both of those instances should have been
17 subject to a full investigation."

18 A further point you highlight in terms of
19 assessment is the lack of reassessment under Mental
20 Health Act, particularly after 11 January, where Beth had
21 returned distressed and without her trousers. And again,
22 you highlight that as an opportunity to change the status
23 of Beth's admission to better protect her, because
24 obviously under the Mental Health Act, she could be
25 detained rather than being present as a voluntary

1 patient. Is that right?

2 A. PAUL: Yes, absolutely. I think, again, it's just to
3 sort of repeat the point, really, but it's just very hard
4 to see where you could ever describe assessment as being
5 effective when there were such inconsistencies between
6 in-patient stays, sections, community care referrals. It
7 just felt a bit of a mess, some illogical discharges, a
8 reactive, sort of crises management approach rather than
9 a really thought out assessment process, yes.

10 Q. You then deal with in-patient admissions as a topic, and
11 at the outset it was identified there were eleven
12 in-patient admissions between 2016 and 2019, and you
13 summarised those under section, two under section 2, four
14 under section 4 and two transfers under section 3,
15 spanning period between May 2016 and 19 November 2018.
16 Against that backdrop, again, you highlight your concern
17 that there was an overall failure to provide therapeutic
18 long-term care for Beth's serious mental illness, and
19 again you describe the system as seeming to lurch from
20 one crisis to another without any informed planning.

21 A. ALEX: Yes.

22 A. PAUL: I think, again, it's just like in terms of the use
23 of sections of Mental Health Act as well, it just again
24 seems wildly inconsistent. If you look at the list of
25 admissions there doesn't seem to be, again, as I sort of

1 mentioned earlier, you would reasonably expect there to
2 be some logic between the events that have happened and
3 the course of action taken by those who were supposed to
4 be taking care of her and actually there just doesn't --
5 we have got a wild escalation of behaviours, and yet no
6 escalation of the use of the Mental Health Act at all.
7 And I think even the fact that she wasn't, according to
8 the records that we have seen, it doesn't seem like she
9 was sectioned at all after November 18 as well, and we
10 know her health really deteriorated at that point, so
11 it's just completely baffling to think that that wasn't
12 seemingly considered.

13 Q. Perhaps to summarise that concern, we see in your
14 statement reference to certain occasions of stated intent
15 by Beth to kill herself, resulting in section, and we see
16 almost exactly the same intention on other occasions and
17 that not resulting in section.

18 A. PAUL: Sometimes it resulted in a stay when she was
19 allowed leave hours after the fact, so yeah.

20 Q. And it's right to say you also make that same
21 observation. I am afraid I am going to have to repeat
22 the word, but you make that same point about
23 observations.

24 A. PAUL: Yes.

25 Q. You observed that there are times when she is on level 3

1 or level 2 or level 1, but the described presentation
2 isn't consistent --

3 A. PAUL: Absolutely.

4 Q. -- with the level arrived at, is that right?

5 A. PAUL: Yes, and again also dropping, I mean we will come
6 to the transfer later, but there is a dropping there
7 between level 3 observations to level 2 observation,
8 which I think was more a miscommunication, but there are
9 even times when that wasn't an excuse, where she would
10 literally be level 2 observations, which as I understand
11 it, four observations per hour, and then to be given
12 leave hours later, again it's just completely baffling.

13 Q. The next topic you deal with is the ward environment, and
14 I have already asked you about Ardleigh Ward and The
15 Lakes, and that eight-month stay in, I believe 2016, and
16 you then also deal, from 10.7, with the two other units,
17 so Thorpe Ward and then Peter Bruff unit. You describe
18 in respect of Thorpe Ward, at 10.7, that it felt unsafe.
19 Can you just explain a bit more about that, please?

20 A. PAUL: Yeah, it's, I visited her there a couple of times
21 and of all the wards, it definitely felt, yes, the least
22 safe. I think a large part of that is probably the fact
23 that it was a mixed sex ward, so there were men and women
24 mingling around. But also the spaces felt very small and
25 very cramped as well, which didn't particularly strike me

1 as particularly safe or welcoming either. And I think,
2 in addition to that, I think even despite our criticism
3 of The Lakes, there was, I felt there was more of a staff
4 presence there. I seem to remember lots of times on
5 Thorpe Ward where it just felt there was no sort of
6 control, and this is purely from my memory, but yeah, and
7 I think those sort of things, the fact it was cramped,
8 the fact it was mixed gender and that, yeah, there didn't
9 always seem to be very present staff I think. It always
10 made it feel a little bit certainly uncomfortable and in
11 my view unsafe.

12 THE CHAIR: Did Beth express concerns about the ward
13 environment and whether she felt safe there?

14 A. PAUL: I don't think she said anything specific about
15 feeling unsafe there herself. I think some of her
16 actions suggest she didn't, but that may have been more
17 to do with her health than the ward environment itself,
18 so I can't say for sure she did.

19 THE CHAIR: And you told us that she talked about the lack of
20 activities and the calendar for activities was blank --

21 A. PAUL: Yes.

22 THE CHAIR: -- apart from the newspaper group. Did she
23 express boredom?

24 A. PAUL: Yes, as we mentioned earlier, you said a second
25 ago, didn't you, when you would come and ask her what she

1 had been up to the answer was invariably, "Nothing."
2 A. ALEX: Nothing.
3 A. PAUL: So yes, I think that was the same across all the
4 wards. I think at that point we were talking about The
5 Lakes rather than Thorpe Ward, but I think it was a very
6 similar scenario from my memory.
7 MR COKE-SMYTH: You perhaps contrast that with your
8 impressions about the Peter Bruff unit, and you say that
9 felt calmer, and there was a greater presence of staff
10 and you say there that your impression was that it was
11 safer. Is that right?
12 A. PAUL: Yes, that was my impression when I visited.
13 Q. The next thing you deal with in your statement is
14 staffing, training and support. One of the points you
15 identify, throughout Beth's care in respect of staffing
16 generally, on all wards, is the high proportion of agency
17 staff. How did you notice that?
18 A. ALEX: So how do we notice that in what sense, sorry?
19 Q. How do you notice that there are agency staff as opposed
20 to permanent staff?
21 A. ALEX: Okay, the fact that every time you visit it's
22 somebody else kind of signing you in, and things like
23 that. I think this kind of came through during the, like
24 under like the Coroner's questioning and stuff because
25 you see this kind of list of staff that were being called

1 up and many of them, like you say, were agency. It was
2 inconsistent, it wasn't always the same people.

3 Q. Could you also differentiate them from what they were
4 wearing?

5 A. PAUL: Yes, I think they all would wear slightly
6 different uniforms, yes, as mentioned in 11.1, yes.

7 Q. And you comment on there seeming to be a high turnover,
8 is that just from your experience of seeing different
9 staff on different days and not seeing the same people?

10 A. PAUL: Yes.

11 A. ALEX: Yes.

12 Q. And you describe it being hard to know who was caring for
13 Beth at any time.

14 A. ALEX: Yes.

15 Q. You also describe, on the Ardleigh Ward, there being an
16 inconsistency whether or not there were staff being
17 outside Beth's room or not. There would be occasions
18 after self-harm where there would be a member of staff
19 and others where there weren't, and you couldn't
20 understand the rationale for that.

21 A. PAUL: Yes, absolutely I remember one specific time when
22 I had gone to visit her and she had, I'm not sure what
23 level this was, but it was a level of observation where
24 the nurse had to be within arm's reach of her at any
25 point. Again, when you see that sort of observation

1 levels increasing you are expecting there is logic to it
2 and reason to it, but then not long later, we have then
3 got those observation levels reducing, and again it
4 doesn't necessarily seem like the behaviour has changed
5 and yet the observation level has.

6 A. ALEX: Yes.

7 Q. And we have dealt with the observations as well, that you
8 suspect in view of your observations previously about
9 staff, that part of the reason may well -- those issues
10 may be turnover and a high proportion of agency staff and
11 your concern being that they are not properly trained?

12 A. PAUL: Yes, not properly trained and also perhaps not
13 there long enough to understand Bethany's long-term care
14 as well.

15 A. ALEX: So I have kind of put that down as a point where
16 I'm saying like more consistent, you know, these clear
17 changes in her behaviour that we can see, like we
18 obviously observed as a family, but we can evidence with
19 her notes. I mean, you know you can't expect someone
20 arriving on to a ward to necessarily be able to notice,
21 you know, notice that this massive change in behaviours,
22 I guess, and we wonder whether that is contributed to by
23 a lack of consistent staffing.

24 Q. And you describe there being poor communication from
25 staff on all wards, and I think you put that in two ways.

1 One in terms of their being aware of Beth's risks. Is
2 that right?

3 A. ALEX: Yes.

4 A. PAUL: Yes.

5 Q. But also in terms of communicating those risks to you as
6 a family?

7 A. ALEX: Yes. The lack of.

8 Q. And we have seen the worst example of that being perhaps
9 the incidents on the 1 and 2 January.

10 A. ALEX: Yes.

11 A. PAUL: Yes, absolutely.

12 Q. You then deal with care management and plans and you make
13 this point at the outset which I am just going to read
14 out. You say this:

15 "One point our sister, Sarah, made in the
16 non-statutory inquiry was that despite reading tens of
17 thousands of pages of medical notes in preparation for
18 the inquest, we never once saw a care plan or any kind of
19 overarching plan in place to actually make Beth better."

20 A. ALEX: Yes.

21 A. PAUL: Yes.

22 Q. And that perhaps links to the earlier section to do with
23 holistic care.

24 A. PAUL: Yes.

25 Q. You didn't see that in the notes and indeed that was the

1 conclusion?

2 A. PAUL: Absolutely, and I think Sarah is sort of
3 vindicated by the independent report as well, which seems
4 to have agreed with that.

5 Q. And as we touched on earlier, you couldn't see any change
6 after 28 October and your father's death. At 12.8 we see
7 the findings of the independent investigation and report
8 because that very much echoes what your sister Sarah has
9 said, and looking at 12.8 it says this:

10 "The general impression provided by the
11 clinical documentation in relation to risk assessment and
12 care planning is poor, a very mechanistic and reactive
13 approach appears to have been taken. The independent
14 investigation team found it surprising how ineffective
15 risk assessment and care planning processes have been in
16 keeping Beth safe and well."

17 As I read earlier, it concluded that it's a
18 fact that none of the interventions over the three-year
19 period served to improve the situation, and it got worse.
20 And although those reasons were multifactorial, there
21 should have been a realisation earlier that things just
22 weren't working.

23 A. ALEX: Yes.

24 A. PAUL: Yes.

25 Q. It also makes this observation at 12.9:

1 "The independent report stated that they found
2 that care plans had been largely cut and paste, with few
3 meaningful objectives and not in sync with the risk
4 assessment and management process."

5 A. ALEX: While that's in inverted commas in the independent
6 report, under questioning from the coroner again
7 clinicians did admit to copying and pasting sections of
8 risk assessment on to discharge and things. You know
9 where the Coroner -- the point being that they should
10 have been reassessed at this point, but instead they are
11 copying and pasting from sometimes days or more earlier.

12 Q. So again feeding into your concern that whatever happened
13 wasn't being reflected in adjustments and changes to
14 care?

15 A. ALEX: Exactly.

16 A. PAUL: Can I just -- before we move on from care
17 management plans, can I just draw a couple of points? I
18 just think there was a paragraph there around Bethany's
19 involvement in care planning and I think any suggestion
20 that that was the case is hard to see as being accurate.
21 When you think about the admission that she made to Open
22 Road about being discharged despite her suicide attempts
23 as well. So it was evident that she wasn't involved in
24 any sort of discussions around her discharges. And that
25 also just brings me on to community care as well, which

1 again findings in the independent report -- I'm not sure
2 if they are quoted in our witness statement or not, but
3 drew like -- there were lots of situations when the care
4 workers would offer odd, odd solutions. So they were
5 there to kind of help her integrate back into the
6 community really, and one such example was that she was
7 offered kick boxing lessons and that appeared to be it.
8 So although that was probably done by a very well
9 intentioned person who thought that would be a nice thing
10 for her to do, it wasn't the kind of rigorous help that
11 she needed in order to be able to sort of, yeah, move
12 into the community and thrive there, really.

13 Q. Again from your description, perhaps not part of any
14 overall plan?

15 A. PAUL: Yeah, absolutely, yes.

16 Q. Thank you. So moving on to your next topic, treatment.
17 You emphasise here again the concerns about lack of a
18 robust diagnostic formulation and your concern about Beth
19 being overmedicated and we have heard your evidence,
20 particularly in respect of how she appeared at your
21 father's funeral. You detail some of the combinations of
22 medication that Beth was being prescribed. Just to
23 summarise, as you set out at 13.8, she was prescribed a
24 combination of mood stabilizers, antipsychotics,
25 antidepressants and benzodiazepines, and we have heard

1 obviously the conclusions of the independent report with
2 which you agree. But you also raise a concern
3 particularly in respect of the benzodiazepines. Can you
4 just explain that concern please and I think you deal
5 with it at 13.9?

6 A. ALEX: Yes, so benzodiazepines, you know, are associated
7 with addiction and she is being, you know, and she has
8 this other diagnosis obviously of the cocaine addiction
9 and stuff as well, you know, and these drugs have been
10 associated with potentially being abused by her. And so,
11 sorry I just want to get my thoughts together and just
12 kind of read back over this.

13 THE CHAIR: Take your time.

14 A. ALEX: So EPUT does not consider this a problem in their
15 factual accuracy response to the independent report which
16 is an interesting document in itself. They actually
17 stated that she was not considered to be an addict by the
18 staff who cared for her and yet this is clear, you know,
19 in her medical records that she is or was a drug addict
20 at this time.

21 THE CHAIR: And had confessed that she had been spending £200
22 a week on cocaine.

23 A. ALEX: Exactly that.

24 MR COKE-SMYTH: So just to summarise your concern there, it's
25 a situation where Beth is clearly taking cocaine, that

1 has been recorded on a number of records as the Chair has
2 pointed out, even to an extent where she is disclosing
3 spending money on it, taking out loans. And that doesn't
4 seem to in any way feed into the decision-making around
5 that, from what you can see.

6 A. ALEX: No, exactly that.

7 Q. You also make the point, going back to the diagnosis of
8 EUPD and reference you made there to NICE guidelines,
9 that those guidelines make very clear, as you set out,
10 that it is very unusual for EUPD to be a condition
11 suffered in isolation?

12 A. ALEX: Yes.

13 Q. It's generally one which is also suffered alongside
14 another condition, so frequently other comorbidities, and
15 here in Beth's case that was her addiction. And you
16 quote the independent report there at 13.11, the report
17 considering that Beth may also have suffered from
18 antisocial behavioural disorder, depression and a
19 significant substance misuse problem, and they consider
20 there should have been a more primary focus on her
21 treatment and you set out there what the report says on
22 that point. It says that:

23 "There is no evidence of any systematic
24 formulation process that would have helped to understand
25 ... (Beth's) co-morbidities better together with a

1 realistic risk assessment and profile, neither was there
2 the proper use of differential diagnoses in the early
3 stages of ... (Beth's) contact with services."

4 And you point out a failure to grapple with
5 diagnosis and that being an underlying issue over the
6 three year period. And you highlight the lack of
7 improvement.

8 A. ALEX: Mmm hmm.

9 A. PAUL: Yes, we have said that she came out almost exactly
10 as she came in and I mean that's true of almost every --
11 it's harder to list the situations when she was
12 discharged from hospital and you felt she was comfortably
13 better than the times when that was not the case, either
14 the same or worse.

15 Q. Moving on to the next topic you deal with, safety. We
16 have heard during the chronology that we've been through
17 of Beth's care that there were serious concerns raised
18 about sexual exploitation and in particular very shortly
19 before her death we heard about the incident on 11
20 January 2019 and you identify here that Beth would
21 continue to be granted leave because she was a voluntary
22 patient and was said to have capacity and, therefore, the
23 staff couldn't stop her and, again, you raised the issue
24 that post certainly 11 January, those events didn't lead
25 to any reconsideration of whether she actually needed to

1 be detained, which would have allowed decisions to be
2 taken to stop leave. Is that right?

3 A. ALEX: Yes.

4 A. PAUL: Yes, I think any reasonable person would see that
5 she was a vulnerable adult and when, and with all of
6 those safeguarding concerns around her, leave was
7 certainly not something to be given completely
8 unrestricted, and I think this 14.1 in particular
9 highlights an actual meeting amongst staff on the ward
10 where it was established that she had £120 in cash and
11 obviously was living with a drug addiction and yet still
12 despite all that knowledge, all those safeguarding
13 concerns, it was deemed as an appropriate
14 course of action.

15 Q. And in particular, in respect of safeguarding forms and
16 the proper process, you have set out at 14.10 that EPUT's
17 own internal investigation concluded that there was a
18 failure on the part of staff on the Peter Bruff Unit to
19 submit relevant safeguarding forms following the
20 disclosure of ongoing exploitation on 12 December 2018.
21 And we have also heard about the lack of handover from
22 staff when she moved from Peter Bruff to Thorpe Ward, so
23 of course there was the immediate risk of self-harm and
24 suicide which wasn't handed over, but also nothing at all
25 about the safeguarding risks which you have set out.

1 A. ALEX: Yes.

2 Q. You highlight the fact that there were two admissions of
3 failure by EPUT at the inquest and just to summarise that
4 the full details are in the narrative conclusion, but the
5 two areas were firstly a failure to ensure a full
6 handover between Peter Bruff Ward and Thorpe Ward on 15
7 January, that was one failure which was admitted. The
8 second failure that was admitted by EPUT at the inquest
9 was that there was a failure to place Beth on the correct
10 observation levels on 15th and 16th January 2019.
11 Turning then to leave -- sorry?

12 A. PAUL: Yeah, no, I was just going to say on that it feels
13 important to come back to that moment -- sorry, I realise
14 we will come on to transfer in a minute, but it's the
15 sort of the lack of communication at handovers I think
16 was something that was really worth flagging, but I
17 realise that is going to come up in a later theme so I am
18 happy to leave that for a moment if that is better.
19 Sorry.

20 Q. Of course. Leave and absconsion, I think we have dealt
21 with the question of observations and what you have said
22 about that, about not being able to understand how, and
23 observations not being set consistently in respect of the
24 risks that Beth disclosed or presented with. And then we
25 have leave and absconsion. Again you make the same point

1 there, that there was an inconsistent approach across
2 Beth's time as an in-patient to leave, and you highlight
3 there the concern that when given leave it would allow
4 her to return with items she could use to self-harm, also
5 illegal substances and in particular you understandably
6 raised the concern that it was during these periods of
7 leave that Beth would then come back and disclose having
8 been sexually exploited, and your concern is that didn't
9 seem to factor into the decision-making as far as you
10 could see.

11 A. ALEX: Yes.

12 A. PAUL: Yes.

13 Q. Was there anything else you wanted to add on that issue
14 before I move on to transfer?

15 A. PAUL: I wondered if it was worth just drawing attention
16 for a moment to 15.5, where we talked about that our
17 mother was normally notified if Beth had a period of
18 leave, but the staff wouldn't necessarily always wait to
19 make sure she was picked up. And actually I feel like
20 you said before you have driven to --

21 A. ALEX: I have done this one as well, yeah, so often -- so
22 what we have got written down here, staff would -- so:

23 "Mum was normally notified if Beth had a period
24 of leave. Staff would not always wait to ensure she had
25 been picked up ..."

1 She would sometimes be waiting outside often
2 unsupervised, and that happened for me once when I went
3 to pick her up to take her up, so shortly after dad
4 passed away, I picked her up to go to visit the town that
5 dad had moved to, it's an unnecessary detail, but again
6 she was outside Peter Bruff Unit on her own and just
7 simply got into the car and kind of said "Hello", and I
8 drove off. There was no real handover or anything at
9 that point.

10 Q. Thank you. Turning then to transfer, this was an area of
11 particular concern and we have the very detailed finding,
12 an admission actually made in respect of that on 15
13 January and we've been through that in terms of the
14 various different failings on that date, in that they
15 weren't aware of her previous history, weren't aware of
16 her level 3 observations or of recent self-harm.

17 THE CHAIR: She was unaccompanied.

18 MR COKE-SMYTH: Unaccompanied as well, perhaps most obviously.

19 A. PAUL: Yes.

20 A. ALEX: Yes.

21 Q. And even there is the fact that there was an e-mail sent
22 which wasn't received, not known why, about her
23 information. In fact, the transfer ought to have
24 included a member of staff, not just out of common sense,
25 but that was indeed trust policy at the time. Is that

1 right?

2 A. PAUL: That's correct.

3 Q. And there obviously should have been a full handover
4 including information about Beth's presentation, history
5 and observation levels. Also, Peter Bruff Ward should
6 have confirmed to Thorpe Ward that it had received the
7 information before the physical transfer and again that
8 didn't happen.

9 A. PAUL: Yes.

10 A. ALEX: Yes.

11 A. PAUL: I think the most frustrating is these all seem
12 like very logical and easy fixes really, certainly
13 considering that on the day of Bethany's transfer from
14 Peter Bruff to Thorpe Ward, of course Peter Bruff as we
15 mentioned had green staffing levels so obviously staffing
16 levels were not a concern, so that's not -- not that it
17 would have been an excuse anyway -- but that couldn't
18 have played into the decision. Then I think, sorry, if
19 you were going to come on to this but to go back to the
20 chronology at 5.106 there was, I believe it was during
21 the inquest, the ward manager admitting to four or five
22 occasions where this was how the transfer was handled,
23 which is horrifying to think that that is almost standard
24 practice, you know.

25 Q. You in fact heard evidence that this wasn't the only time

1 it had happened?

2 A. PAUL: Yes, I believe it's in 5.016 of our statement.

3 Q. The other issue in respect of transfer is again the trust
4 also admitted that there should have been a consultant to
5 consultant discussion about Beth's history, the current
6 treatment plan and her ongoing risks, and there should
7 have been a full handover on her arrival. So that
8 perhaps deals with the issue of transfer on the 15th, but
9 you have also described other occasions where you have
10 had concerns about staff not being aware of Beth's level
11 of risk and background. Is that right?

12 A. ALEX: Yes.

13 A. PAUL: And I also think it's probably worth, just on the
14 subject of transfers generally, like the way in which
15 Beth was bounced around between ward to ward, it seems
16 completely reasonable to think that would be very
17 unsettling for her and hard for her to even see that
18 again there is a long-term plan for her health if they
19 can't ever make their mind up as to where -- I mean,
20 obviously we understand there are sort of bed space
21 concerns and things like that, but for someone who was
22 living with what Bethany was, you can imagine how
23 unsettling that would have been to have been not sure
24 where you were going to spend the next night in some
25 ways.

1 Q. You then deal with the question of discharge and
2 continuity of care and treatment in the community. And
3 we've been through in the chronology now the instances of
4 particular concern about discharge, so 3 January being
5 the most obvious following the two near misses. You also
6 highlight discharge on 18 December 2018 and 22 November
7 2018, as well as 13 August 2018, Beth being discharged
8 despite having chronic suicidal thoughts and notes
9 referring to her disclosing to staff an intention to kill
10 herself. And you again detail, in your view, the fact
11 that the community care didn't appear to be particularly
12 structured and appeared quite random in terms of offers
13 to meet with Beth.

14 Family engagement, again you have dealt, I
15 think we have dealt with this throughout the chronology,
16 but would it be perhaps fair to say that that was a
17 concern in terms of what the family were told about Beth,
18 particularly most obviously post 1 and 2 January, but I
19 think you describe that being an issue on other
20 occasions. You also describe, in particular your mother,
21 who was involved directly in some of the discharge
22 plannings. You say at your 18.1, that even:

23 "... on those occasions where she attended
24 meetings with Beth's treating teams, she rarely spoke or
25 was acknowledged" -- and you say that she -- "always had

1 the distinct impression that she was not wanted there."

2 A. ALEX: Yes, absolutely.

3 A. PAUL: I think that is one of the points that we raised
4 during the chronology, that you expect the community care
5 team to sort of -- sorry, that's not the community care
6 team that's a separate point, but even so, if you are
7 dealing with the family of patients you expect a warmth
8 there anyway but when you are also factoring in the fact
9 that mum lives with mental health herself, it seems
10 especially important to consider that, and I just don't
11 think it ever felt like that from her perspective.

12 Q. Yes, so two aspects there then, in terms of the actual
13 involvement not in your view being particularly
14 meaningful, and then on the other side being discharged
15 to your mum without really thinking about the impact that
16 might have as well.

17 A. Yes.

18 Q. Turning then to the next section, concerns about
19 complaints, quality, timeliness, openness and
20 transparency. One significant concern that you raise is
21 in respect of the retrospective entry made to the
22 observations on the night of Beth's death on 15 January.
23 Those observations were made, or recorded I should say,
24 by an agency nurse and you describe in your statement how
25 it became clear during the inquest it was indeed accepted

1 that the record was not contemporaneous, it had been made
2 sometime later, and you felt that when it became clear
3 that the entry was in fact false, you felt that EPUT
4 tried to minimise that in your view?

5 A. PAUL: Yes, absolutely, and I think it again just speaks
6 to this sort of culture where it was more important for
7 them to just tie up that loose end and make sure that
8 their tracks were covered in that sense rather than
9 actually recognising that that was potentially a failure
10 that whether the observation happened or not, and I think
11 we as a family accept that it didn't. But I think at any
12 rate there was obviously a process that wasn't working
13 there and rather than sort of address that in a
14 meaningful way, it was minimised in their serious
15 investigation report and almost sort of glossed over. In
16 some ways I feel like we were -- I don't want to sound
17 too conspiratorial but I feel like someone must have
18 slipped otherwise I wonder whether we ever would have
19 even found out about that, you know, such was their
20 priority on covering their own backs, rather than
21 actually addressing the concerns.

22 Q. You also highlight in terms of openness your concern that
23 records, particularly the DATIX records, were disclosed
24 halfway through the inquest, in your words?

25 A. PAUL: Yes.

1 Q. And we have looked at the DATIX in particular and on the
2 1st and 2nd January and we have seen how those two near
3 misses were classified in those records and again that's
4 a serious concern to you as a family?

5 A. PAUL: It certainly is and also I think that's not the
6 only example of a self-harm incident in the DATIX
7 records, where it was linked to -- listed as "no harm" or
8 "low harm" as well. So that's a pattern of
9 underreporting or minimisation.

10 Q. I am going to turn now then to the topic of quality and
11 --

12 A. PAUL: Sorry, is it okay just really quickly, I just
13 quickly want to draw attention to 19.6 to 19.7 where we
14 just sort of recount the way that our mother was told
15 about Bethany's death?

16 Q. Yes.

17 Q. PAUL: Because we feel that is a really important thing
18 to be heard. So first of all, as I understand it, mum
19 was trying to contact the ward because she hadn't heard
20 from Bethany for a long time, was told that they were in
21 a handover meeting and somebody would call soon. There
22 was then a follow-up call from a doctor who essentially
23 gave a blow-by-blow account, as we have put it in the
24 statement, of how Bethany was found and then
25 resuscitation attempts and giving sort of unnecessary

1 medical details and it actually, to my mum's
2 recollection, she actually had to interrupt the person
3 calling and ask the question, "Is she dead?" to actually
4 find out what had happened. I think it just shows, like,
5 for us, a real lack of compassion and a lack of
6 understanding of how to deal with bereaved families on
7 the trust's part?

8 Q. Thank you.

9 THE CHAIR: Investigation?

10 MR COKE-SMYTH: The investigation. You were told in January
11 2019 that there would be an internal investigation by
12 EPUT and a family liaison officer would be appointed. I
13 would just like to summarise this; there were delays in
14 hearing back from EPUT and then in finding a time to be
15 able to meet. It was then, in April 2019, that you heard
16 from NHS England that there was going to be an
17 independent investigation and that being the
18 investigation we have referred to which resulted in the
19 reported which you have quoted in your statement. In
20 terms of EPUT's own internal investigation, in June 2019
21 you were told that it had been delayed you would get it
22 at the end of July, you didn't receive it, and then you
23 got a draft and then got a final version in September
24 2019 and then, the next step in the chronology of the
25 reporting was you got the independent investigation

1 report on 20 March 2020?

2 A. PAUL: Can I just really quickly come in because I think
3 this probably links almost to the last section on
4 concerns and complaints really, but it is worth noting
5 that in 20.11 Sarah actually -- our sister Sarah had to
6 actually chase the serious incident report as well.
7 Again just coming back to this culture of not really
8 treating families with compassion. We sort of had
9 expected a delayed report so that was fine, but you don't
10 expect to have to chase after that. And I think also,
11 this is not relevant, but I just want to say that
12 actually I very much feel and I think the whole family
13 feels that without Sarah's advocacy for Bethany we would
14 probably not have got anywhere, which is not relevant
15 evidence, but I just wanted to say that out loud.

16 Q. Thank you, that's helpful. So you then received the
17 independent report on 20 March 2020 and as we have seen
18 in the course of your evidence, you strongly agree with
19 certain aspects of that report and the next thing that
20 happened in the chronology is there was a response to
21 that independent report on behalf of EPUT. Is that
22 right?

23 A. ALEX: That's correct.

24 A. PAUL: That's correct.

25 Q. And that response you set out, you deal with this at your

1 paragraph 20.15, the response was provided by Dr Karale
2 in a document dated 24 January 2020, and you set out
3 there in summary EPUT's position in response to some of
4 these points we have heard about from the independent
5 report. Firstly, the response disagreed with the report
6 suggesting that Beth was likely suffering comorbidities
7 and it raised the point about this being beyond the
8 scope. Secondly, it disagreed that Beth had substance
9 abuse problems and it was suggested that there wasn't
10 evidence that that was the primary issue. Thirdly, it
11 made reference to issues between the two record sharing
12 systems talking to each other.

13 A. PAUL: Can I just jump in for one second? Because
14 there's just another point that I feel is important here,
15 which is the sort of comment on, and I think I mentioned
16 this earlier on in the chronology, the comment around
17 blood pressure medication.

18 Q. Yes.

19 A. PAUL: And it just -- this factual accuracy response for
20 me captures the sort of tone and the defensiveness of
21 EPUT's approach to Bethany's case where Dr Karale chose,
22 instead of again engaging with what the report was
23 actually saying and the failings that it was
24 highlighting, found it appropriate to comment that the
25 blood pressure medication was needed in a section of the

1 report which was clearly not focused on that part of the
2 medication that was being called into question as well.

3 Q. So perhaps from your point of view not seeing the wood
4 for the trees, to put it --

5 A. PAUL: Exactly. And it felt almost intentional as well,
6 like it didn't ... yeah, it's opting to nitpick instead
7 of actually really engaging with the substance of what
8 the independent report was saying.

9 Q. And just pulling that together, your concerns at EPUT's
10 response to the independent report, you set those out at
11 20.17, and again you have referred to them already but
12 perhaps just to summarise, your concerns at that response
13 were as follows; firstly, the downplaying of the two near
14 miss incidents, even in the EPUT serious investigation
15 report, and you make the point that you didn't appreciate
16 the significance of those incidents until you got the
17 independent report; secondly, the insistence that the
18 medication regime was adequate and the issue that it
19 wasn't accepted that Beth was an addict; thirdly, you
20 highlight the defensiveness about diagnosis and fourthly,
21 you highlight the lack of a formal EUPD pathway.

22 A. ALEX: Yes.

23 A. PAUL: Can I also just really quickly, a note I made
24 right at the start of this morning, where obviously we
25 have, like, we have come back a lot to the lack of a

1 coherent diagnostic process, and it's worth bearing in
2 mind that part of EPUT's response was to push back and
3 saying, "Actually looking at a holistic framework of
4 diagnosis, et cetera was beyond the scope of the
5 independent report", and then later on, of course, the
6 coroner looked at that as a vital part of the inquest as
7 well. So I think that just vindicated that that was the
8 right lens to be looking at it in, and it was upsetting,
9 to say the least, to know that EPUT felt that was beyond
10 the scope of the report.

11 Q. We will come on to in a moment, of course this was all
12 before the inquest into Beth's death. As we will see
13 when we get to that section, the failure in diagnosis was
14 indeed a finding made at the inquest amongst other
15 further failings.

16 A. PAUL: Yes.

17 A. ALEX: Yes.

18 Q. You deal then with the question of meetings about lessons
19 learned. Perhaps to summarise that, you certainly felt
20 there was a meeting, you were given a document, which I
21 think you describe as being a print-off of a PowerPoint.

22 A. ALEX: We still have a digital copy of this report and it
23 is in fact a PowerPoint file.

24 Q. You describe I think a number of spelling errors, you
25 describe there being little detail and you describe much

1 of the space taken up by a pathway diagram, which I
2 think, according to your statement, you didn't find
3 particularly helpful or enlightening in respect of the
4 issues raised in Beth's case.

5 A. PAUL: Can I just really quickly speak on that as well,
6 which is from my perspective specifically at that point
7 when we had this lessons learned meeting, I was actually
8 living in America and so there was a five hour time
9 delay. I woke up early, I think like 4 am or 5 am, in
10 order to attend this meeting virtually to then have EPUT
11 representatives present this absolutely shambolic attempt
12 at a document. It was very frustrating -- but then also
13 you are probably going to go on to it, so apologies. But
14 to then be told, the bulk of the meeting was, "We are not
15 going to go through this line by line, here you go",
16 essentially and then the meeting was over in sort of less
17 than twenty minutes really. So it felt like they had
18 kind of put some effort into creating this document, but
19 actually clearly there wasn't much thought process behind
20 it because they weren't even able to fill an hour-long
21 meeting to talk about it and walk us through it. They
22 just said, "We are not going to walk you through it line
23 by line."

24 A. ALEX: They gave us a period of time to respond to it.
25 As a family we had all driven all the way up to Witham to

1 be sat in a room, given a piece of paper and told, "Off
2 you go", essentially.

3 Q. Thank you, that is helpful. I am going to move on now to
4 a section of your statement where you deal with the
5 subsequent legal proceedings, so that being the inquest
6 which took place. So that took place after the
7 independent investigation report had been provided to
8 you, also after EPUT's internal investigation had taken
9 place, but also after the meeting you have just described
10 in respect of lessons learned. That inquest took place
11 between February and March 2022, and as I referred to
12 earlier, the inquest was heard with a jury and a
13 narrative conclusion was returned.

14 We dealt with the earlier admissions made by
15 EPUT. Those admissions were twofold: a failure to hand
16 over between Peter Bruff and Thorpe Ward on 15 January,
17 and also a failure to place Beth on correct observations.
18 That is what was admitted, and then it is right to say
19 that the remaining parts of the conclusion were not
20 admitted, but were subject to findings in the course of
21 the inquest. Is that right?

22 A. ALEX: Yes.

23 A. PAUL: Yes.

24 Q. So the jury concluded in their narrative that her death
25 had been contributed to by neglect and referred to

1 certain gross failures, which made up that finding, but
2 they also made findings that a number of areas
3 contributed to Beth's death. Just looking at those, we
4 can see that they, to some extent, mirror some of the
5 areas in the investigation report and also, as you have
6 detailed, some areas that weren't admitted by EPUT in
7 their response. So the first, I am looking at 21.5, the
8 first was there was a finding contributing to Beth's
9 death that there was a failure in the diagnostic
10 formulation process?

11 A. ALEX: Yes.

12 A. PAUL: Yes.

13 Q. Secondly, that there was a lack of adequate
14 documentation, recordkeeping, by EPUT and that included
15 inadequate care plan, inadequate discharge summaries,
16 failure to complete risk assessments, incomplete level 1
17 observation sheets on 16 January, inadequate monitoring
18 of leave on the 16th and also an inability to access all
19 patient record systems. There was also the fact, or
20 there was also the further risk assessment and risk plan
21 which weren't undertaken between 11 January, that being
22 the date we have heard about the state Beth came back to
23 the ward in and her death. They also included the use of
24 the two different record systems meaning that Beth's
25 history could not be accessed. In terms of gross

1 failings, those included lack of recordkeeping, risk
2 assessments, lack of proper handover to Thorpe Ward and
3 the failure to keep Beth on correct observations.

4 Finally, it is right to say the jury also made
5 a finding that the proposed discharge date for Beth of 22
6 January was inappropriate, and it was also found that
7 observations weren't carried out properly on 16 January,
8 and that being a reference to the observations in the
9 evening where you have told us about the record being
10 completed retrospectively.

11 A. ALEX: Yes.

12 Q. Just to summarise, because I think we've been through
13 this in detail, we have heard about the DATIX, but as a
14 result of that inquest and that process, you had two main
15 concerns. Firstly disclosure of documents and
16 information, most seriously the DATIX, which we have
17 looked at, and it would be fair to say, as you have set
18 out in your report, in light of your experience, you
19 don't or it is fair to say you are sceptical of evidence
20 from EPUT that it takes its response to inquests
21 seriously.

22 A. ALEX: Yes.

23 A. PAUL: I think there's just like a feeling of
24 unpreparedness really from most of their witnesses that
25 they called and it was, yes, just felt pretty devalued as

1 a family, as a result.

2 Q. I am going to move on now to the final section, unless
3 there is anything else you want to add in respect of the
4 inquest?

5 A. PAUL: No, I think I have raised everything I want to.
6 Is there anything?

7 A. ALEX: I think so, no -- yes. As in, no, I have nothing
8 more to add, thank you.

9 Q. If you are content, I will carry on now to the end, if I
10 may.

11 A. PAUL: Yes.

12 Q. So drawing all those points together, you set out in part
13 3 certain recommendations that you make, and I should
14 make clear that, as you set out, these are only
15 provisional because of course you haven't heard all the
16 evidence of the public inquiry.

17 A. ALEX: Exactly.

18 Q. And these are points that you raise now, at this point,
19 to assist the Chair.

20 A. PAUL: Yes.

21 A. ALEX: Yes.

22 Q. The first point or recommendation, which you suggest, is
23 you highlight the problem of a lack of robust diagnostic
24 framework for EUPD and an approach which emphasised
25 treating symptoms rather than underlying issues, and the

1 underlying cause. Your first point is that you urge the
2 trust, so EPUT, the take steps to establish a robust
3 pathway for treatment for EUPD.

4 Can I just ask you to explain what do you mean
5 by that, establish a robust pathway?

6 A. PAUL: Again, we not medical professionals by any means,
7 so we are not entirely sure what that should look like in
8 practice. But obviously I understand there was obviously
9 a recommendation made strongly by the independent report
10 and I think for me, what it means is, as we have sort of
11 outlined here, rather than this sort of fire fighting
12 approach, or sort of sticking plaster approach to her
13 care, actually thinking, "Right, who is Bethany as a
14 person? What are the underlying issues that need to be
15 addressed here?" Really, yeah, planning care for her --
16 in her case, planning care for patients with EUPD that
17 see them as a whole person and realise the underlying
18 issues are and adapt the care accordingly.

19 A. ALEX: Yes.

20 Q. Linked to that your next proposal is 22 .3, you highlight
21 the need for good support services both for sufferers of
22 EUPD, but also importantly those caring for them and you
23 urge there to be sufficient funding to support those
24 types of services?

25 A. ALEX: Yes.

1 Q. The next recommendation, or proposal, that you have is at
2 22.4, and this is where you describe in your view a
3 closed culture at the trust, when it came to informing
4 you about changes to Beth's risks while she was an
5 in-patient, so not telling you when there had been these
6 serious incidents and not passing on information. You
7 say that:

8 "We would welcome more open communication
9 between staff and family members and a change to a
10 culture which either downplays change to risk or does not
11 communicate risk at all."

12 A. ALEX: Yes.

13 Q. Linked to that, but significantly in view of the evidence
14 you have given about the 1 and 2 January incidents, you
15 say in your view there should be mandatory reporting of
16 all near misses, and the family must be informed in every
17 instance where there is a near miss. Clearly from your
18 evidence, had that happened in Beth's case, that would
19 have made a difference to you?

20 A. ALEX: Yes.

21 A. PAUL: Yes, absolutely, and I think that also ties in
22 with one of the later recommendations as well that we
23 need to have confidence in the reporting of these
24 incidents as well because at the moment if the two near
25 misses were regarded as low harm or no harm, then by that

1 recommendation, if that were accurate, we wouldn't have
2 heard about them at any rate. So I think it goes side by
3 side with, that one that comes later.

4 Q. Your next recommendation is for there to be greater
5 involvement of the family in discharge and care planning.
6 We have heard the basis for that, we have heard the
7 difficulties with discharge planning and also involvement
8 of your mother in that process and the issues which you
9 have set out surrounding that and you say where there is
10 a requirement to involve families there must be more than
11 lip service.

12 A. PAUL: Absolutely.

13 Q. And also you highlight the need for there to be adequate
14 support to the carer to whom that discharge is being
15 made, and the need, in your view, for there to be a
16 safeguarding assessment.

17 A. PAUL: Yes, absolutely, I think in this one we are sort
18 of thinking as well about everyone that's involved in the
19 care of Bethany as well. So actually like where a
20 vulnerable person is being sent into the care of someone
21 who also could be considered vulnerable in some ways,
22 that should be taken on board and there should be a real
23 vigorous and thorough plan in place as to how both those
24 are going to be managed.

25 Q. Your next proposal is in respect of transfer and you

1 propose, in addition to there needing to be training, to
2 ensure a full handover takes place, you propose there
3 should be minimum standards as to what any handover
4 should involve and we have heard just how badly wrong
5 that went in Beth's case?

6 A. ALEX: Yes.

7 Q. Where there wasn't any?

8 A. PAUL: Again it comes back to something I said earlier,
9 like it doesn't seem like a hard thing to fix and in fact
10 the trust's policies at the moment say that a member of
11 staff should go there, so there was a failing there.
12 Even so, we understand there was an e-mail sent but no
13 follow-up, there was no -- no one seemed desperate to
14 find out if that information had been received and
15 understood, and if that takes a phone call, then it's
16 hard to see why that didn't happen and why it certainly
17 shouldn't happen in all future cases.

18 A. ALEX: Yes.

19 Q. The next point you recommend is to summarise really,
20 action to ensure the accuracy of DATIX reporting, so that
21 families can have confidence in that, and obviously that
22 arises in particular from the 1 and 2 January. But also,
23 as you detailed earlier, you believe there are wider
24 concerns around that, and you believe action needs to be
25 taken to ensure there is confidence that it accurately

1 records what has happened.

2 A. PAUL: Yes.

3 Q. Next, you deal with culture and I am just going to read
4 this aspect of your statement. You say this at 22.9:

5 "The defensive culture, which we experienced
6 after the death of our sister is something no family
7 should have to endure after facing a bereavement. From
8 the stand-offish and defensive response of the Trust to
9 the independent report, to the defensive attitude of
10 witnesses at the inquest to the late disclosure halfway
11 through the inquest process of key documents. It felt
12 like our search for answers was being frustrated at every
13 turn. It fell to us, for example, to chase for updates
14 about the serious investigation report and it took
15 complaining to the Coroner to even get a first phone call
16 from our family liaison officer. The trust must learn to
17 deal with bereaved families with compassion and
18 openness."

19 Is there anything you would like to add to
20 that?

21 A. PAUL: I mean in honesty, I think, yeah, there are so
22 many examples of where we have seen that and just, yeah,
23 you just feel very devalued when you are not taken
24 seriously in a situation like this. And again, just to
25 come back and say that without Sarah, this -- we perhaps

1 wouldn't even be here now, having the opportunity to
2 share this, and it shouldn't fall on the family to chase,
3 and when families are desperate for answers the immediate
4 response should not be one of defensiveness and trying to
5 shut down and frustrate that process.

6 A. ALEX: Yes.

7 THE CHAIR: Can I just be clear, was the family liaison
8 officer the Coroner's family liaison officer?

9 A. PAUL: I'm not sure, I didn't think so. I think that was
10 the trust's family liaison officer, as I remember it.

11 A. ALEX: There was a family liaison officer mentioned
12 earlier, wasn't there?

13 A. PAUL: Yeah.

14 THE CHAIR: Don't worry we will chase that down.

15 MR COKE-SMYTH: Thank you, Chair. Your next proposal is that
16 there should be a national oversight mechanism, which is
17 independent and can properly scrutinise the
18 implementation of recommendations.

19 A. ALEX: Yes.

20 A. PAUL: Yes, we felt the Inquest's opening statement
21 really set out that case very clearly and we support it.

22 Q. Finally, you deal with information, perhaps a simple
23 proposal, to what is no doubt not a straightforward
24 problem, but you identify the need for all staff to be
25 able to access all information about any patient and

1 that's obvious, given the evidence you have given about
2 Beth and her circumstances.

3 A. ALEX: Yes. I mean, in the response to the independent
4 report letter, you know, they mention about these systems
5 that are not talking to each other. It's, you know I
6 feel that that -- should that not be a legal requirement
7 that if you have computer systems, okay you can have
8 different computer systems, but within the same trust
9 important information should be able to be disseminated
10 between them. I don't think that's unreasonable.

11 Q. That takes to us the end of the section dealing with
12 recommendations. Chair, do you have any questions at
13 this point?

14 THE CHAIR: No, I don't.

15 MR COKE-SMYTH: Thank you very much for your evidence. Unless
16 there is anything further you would like to say now, we
17 are going to take a break in which we will be considering
18 whether there are any further questions we need to ask.
19 There may not be. So with that in mind, is there
20 anything else you would like to add to any aspect of your
21 evidence today?

22 A. PAUL: No, I don't think so.

23 A. ALEX: No.

24 A. PAUL: We have covered everything very thoroughly.

25 THE CHAIR: Can I take therefore this opportunity to thank you

1 both very much indeed for your evidence. It is very
2 helpful.

3 MR COKE-SMYTH: Chair, before we rise there is also the time
4 we propose to put up a picture of Beth, so perhaps we
5 could have that on screen. Thank you. So those are all
6 the questions I have. As I say, we will consider whether
7 there are any more and, Chair, perhaps we could return in
8 45 minutes, after lunch. Thank you.

9 (1.14 pm)

10 (Break for lunch)

11 (2.04 pm)

12 THE CHAIR: Ms Lloyd-Owen?

13 MS LLOYD-OWEN: Chair, this afternoon we have evidence from
14 Jane Stanford. Please could the witness be sworn.

15 JANE STANFORD (affirmed)

16 Examination by MS LLOYD-OWEN

17 Q. Please could you state your full name for the record?

18 A. Jane Dorothy Stanford.

19 Q. You are the daughter of Dorothy, known as "Dot" Redditt,
20 who was born on 8 March 1936 and died between 15th and 16
21 March 2021 at the age of 85, is that right?

22 A. That's correct.

23 Q. You would like me to refer to your mother as "Dot"
24 throughout my questions?

25 A. Yes.

1 Q. And would like me to call you Jane?

2 A. Yes.

3 Q. By way of background, the Inquiry sent a rule 9 request
4 for evidence to your legal representatives on 28 January
5 this year, and in response to that request that you have
6 provided a witness statement to this Inquiry. You have a
7 copy of that witness statement in front of you. Is that
8 right?

9 A. Yes.

10 Q. It is 64 pages long and it is dated 25 June of this year.

11 A. That's right, yes.

12 Q. At page 62 you made a statement of truth and then signed
13 the witness statement. If you turn to almost the last
14 page --

15 A. Yes.

16 Q. -- you should see that there.

17 A. I have, yes.

18 Q. Now, I am going to be asking you a number of questions if
19 you could keep your voice up as much as you can.

20 A. Okay, will do.

21 Q. Thank you. Can I confirm have you had an opportunity to
22 read through your statement recently?

23 A. I have.

24 Q. I understand there are two matters of correction to
25 address and I will just deal with those now. Firstly if

1 you turn to page 101 of your witness statement --
2 apologies, paragraph 101 of your witness statement, which
3 you will see at page 18.

4 A. Yes.

5 Q. We see there that your mother is assessed by Dr A, and it
6 is recorded there as being dated 20 January 2021. To
7 clarify, is it right that based on the documentation you
8 have seen, you understand the assessment of your mother
9 by Dr A took place on 19 January 2021?

10 A. That's correct, yes. The date is of when the report was
11 actually prepared.

12 Q. If you could try and keep your voice up just a little
13 bit?

14 A. Sorry.

15 Q. You were saying when the report was written up. Is that
16 correct?

17 A. That's right, on 20 January it was written up, but the
18 assessment happened on the 19th.

19 Q. Thank you. I also want to deal with a matter of
20 correction in relation to paragraph 1 of your witness
21 statement, on the first page. We see there that it
22 records your mother's death as occurring on 16 March
23 2021. At paragraph 273 you state that the Coroner placed
24 an approximate time of death of your mum being between 15
25 and 16 March 2021. Is it right that you understand that

1 your mother's death occurred between the 15 and 16 March?

2 A. Yes, I do.

3 Q. Thank you. Aside from those corrections, is your
4 statement true and accurate to the best of your knowledge
5 and belief?

6 A. It is.

7 Q. Thank you. As you know, this witness statement will
8 therefore stand as your evidence to the Inquiry.
9 Although I am going to ask you questions about this
10 witness statement, I am not going to go through every
11 line or ask you to read it out. Please, do be assured
12 that the Chair and the Inquiry team have read and
13 considered everything you have said in that statement
14 very carefully, and it will form part of the body of the
15 evidence on which the Inquiry will rely. I also would
16 like to acknowledge that you have provided a
17 commemorative and impact account in relation to your
18 mother, Dot, and the Inquiry is extremely grateful to you
19 for that evidence as well as the evidence you are giving
20 today.

21 I would like to remind you that I will not be
22 asking you to name any individual members of staff today,
23 so please try not to do so, and we will be taking a break
24 every hour, but if you require further breaks, please do
25 bring my attention to it.

1 A. Thank you.

2 Q. Your evidence will focus on your concerns in relation to
3 your mother's care and treatment under the care of Essex
4 Partnership University NHS Foundation Trust, which we
5 will be referring to as EPUT. You state that the events
6 within your statement come from both your recollection,
7 what you have been told by others, including your father
8 and your aunt and also documents that you have in your
9 possession, including those you list on the last two
10 pages of your statement. Is that right?

11 A. That's correct.

12 Q. I would like to start by setting out a timeline of Dot's
13 involvement with Essex Mental Health Services. I will
14 summarise the timeline and key dates from your witness
15 statement, but please do stop me if I summarise anything
16 incorrectly. Please do feel free to refer to your
17 statement as you wish throughout my questions.

18 As I understand it, according to your witness
19 statement, your mother had a longstanding history of
20 mental ill health. When she was about 30 years old she
21 sought help from her GP for low mood, with treatment for
22 depression beginning at that time and she remained on
23 medication from that point onwards.

24 A. That's correct.

25 Q. Over the years your mother frequently experienced cycles

1 of withdrawal, rage and emotional shut down, and as far
2 as you were aware, there was no formal diagnosis provided
3 by anyone other than the GPs who treated her over those
4 years.

5 A. That's correct.

6 Q. In October to November 2018, your mother experienced a
7 serious deterioration in her mental health whilst
8 transitioning between two antidepressant medications.
9 After she left the house and police were called, she was
10 taken to Broomfield Hospital Accident & Emergency for a
11 mental health assessment but was not admitted; is that
12 right?

13 A. That's correct.

14 Q. After this time, your mother's previously episodic
15 withdrawal and rages evolved into a persistent low mood
16 coupled with irritability and aggression; is that right?

17 A. That's correct.

18 Q. Moving forward to November 2020, at your mother's
19 request, the GP change her antidepressant medication
20 from sertraline to mirtazapine, leading to a further
21 decline in her mental health, with signs of manic
22 behaviour, agitation and irritability?

23 A. That's correct.

24 Q. And in late December 2020 to early January 2021 your
25 mother's mental health continued to deteriorate. She was

1 highly irritable, aggressive and manic.

2 A. That's correct.

3 Q. At this time you observed your mother's behaviour to be
4 very paranoid and you describe your father telling the GP
5 that your mother was experiencing insomnia and was
6 shouting and crying.

7 A. That's correct.

8 Q. On 18 January 2021, your mother threatened to kill your
9 father, hit him over the head with a remote control and
10 locked him out of the house; is that right?

11 A. That's correct.

12 Q. When she would not let your father back into the house a
13 neighbour called the police. You and a police officer
14 entered the address with your spare key and after
15 attempting to speak to your mother, you took your father
16 with you and left your mother at the address, calling the
17 GP thereafter to explain your concern for your mother's
18 safety, and the GP confirmed that she would call the
19 Access Team to visit your mother at home that evening.

20 A. That's correct.

21 Q. Later that afternoon, still on 18 January, your mother
22 called the GP surgery to report that she had taken an
23 overdose. The GP called an ambulance for her and she was
24 taken to Broomfield Hospital Accident and Emergency.

25 A. That's correct.

1 Q. Your mother underwent a mental health assessment and
2 agreed to voluntary admission to Ruby Ward at the Crystal
3 Centre.
4 A. That's correct.
5 Q. You were informed that if she had refused voluntary
6 admission she would have been sectioned.
7 A. That's correct.
8 Q. Your mother then spent two days at Heybridge Ward.
9 A. That's correct.
10 Q. And on 19 January she was assessed by a consultant
11 psychiatrist who we will be referring to as Dr A.
12 A. That's correct.
13 Q. She was diagnosed with bipolar affective disorder and
14 your mother was then admitted to the Ruby Ward.
15 A. That's correct.
16 Q. On 22 January your mother was assessed by another
17 consultant psychiatrist who we will be referring to as
18 Dr B. You spoke to Dr B that day and he told you that
19 your mother had borderline personality disorder; is that
20 right?
21 A. That's correct.
22 Q. That this was not a mental health disorder, that your
23 mother could, therefore, not be sectioned and that he had
24 withdrawn all her medication?
25 A. That's correct.

1 Q. On 9 February, you and your family attended a
2 multidisciplinary video call Teams meeting with Dr B,
3 Social Services and others to discuss the safeguarding of
4 your father.

5 A. That's correct.

6 Q. You were told that the conclusion of the safeguarding
7 investigation was outstanding and that your mother was
8 free to self-discharge and that if she did so the police
9 would be called; is that right?

10 A. That's correct.

11 Q. On 14 February, whilst your mother was still an
12 in-patient at Ruby Ward, your mother's care plan recorded
13 that if she attempted to leave the ward, due to the
14 ongoing safeguarding investigation, that police would be
15 informed and she would potentially be held under section.

16 A. That's correct.

17 Q. On 15 February, ward staff called your father and then
18 you insisting that your father return your mother's keys
19 to the house as she wanted to come home and threatening
20 police action.

21 A. That's correct.

22 Q. On 20 February, your mother discharged herself from Ruby
23 Ward at which point, in accordance with Dr B's plan, the
24 police were called to attend but refused on the basis
25 that it was a matter for Social Services; is that right?

1 A. That's correct.

2 Q. Social services were not contacted at this point but an
3 on-call registrar persuaded your mother to return to Ruby
4 Ward. On 22 February, your father received a further
5 call from Ruby Ward staff insisting that he agree to your
6 mother coming home; is that right?

7 A. That's correct.

8 Q. On 4 March, your mother then discharged herself from Ruby
9 Ward, returning to the home address she had previously
10 shared with your father and as advised your father called
11 the police who attended and sought emergency
12 accommodation for your mother as social services had not
13 been notified of her discharge; is that right?

14 A. That's correct.

15 Q. On 5 March, you contacted Social Services who collected
16 your mother from the overnight accommodation the police
17 had arranged and arranged temporary accommodation for
18 her.

19 A. That's correct.

20 Q. On 9 March, your mother took an overdose, you were
21 contacted by a doctor at Broomfield A&E that evening
22 seeking background information; is that right?

23 A. That's correct.

24 Q. Your mother was then discharged at 11 pm back to her
25 temporary accommodation and neither you nor Social

1 Services were notified of her discharge.

2 A. That's correct.

3 Q. On 10 March, there was a multidisciplinary team
4 discussion about your mother, at which concerns were
5 raised about diagnosis, isolation and overdose risk; is
6 that right?

7 A. Yes.

8 Q. On 12 March, your mother's care co-ordinator informed
9 your mother that she had been referred to Home First, but
10 when she refused visits from the Home Treatment Team and
11 denied suicidal ideation, the gatekeeping assessment was
12 withdrawn.

13 A. That's correct.

14 Q. On 13 March, your mother returned to your father's and
15 formerly her home address. Police were again called, but
16 rather than persuading your mother to return to her
17 temporary accommodation, your mother was readmitted to
18 the address and you and your father were arrested.

19 A. That's correct.

20 Q. On 15 March, you notified social services of this
21 incident that had taken place on 13 March.

22 A. That's correct.

23 Q. The following day, on 16 March, your mother was found
24 dead at your parents' home address locked in the bathroom
25 with evidence of self-harm.

1 A. Yes, that is correct.

2 Q. You understand that there was a post-mortem examination
3 which took place and which concluded that the cause of
4 death was old age.

5 A. That's correct, yes, as they couldn't find any
6 correlation between the self-harm and her death.

7 Q. Thank you. And you understand that your mother died, as
8 we have discussed, between 15th and 16th March.

9 A. Yes, that is correct.

10 Q. Are you happy that that is a summary of the key
11 chronology of the dates and events taken from your
12 witness statement?

13 A. Yes, to the best of my knowledge, yes.

14 Q. Thank you. I am now going to ask you some questions
15 about your concerns in relation to your mother's care and
16 treatment and I will go through those them thematically
17 and start, firstly, to ask you some questions about your
18 concerns in relation to your mother's unclear diagnosis
19 and the impact that this had on her treatment. I am
20 going to refer to different parts of the witness
21 statement. If it helps you I am going to start by
22 looking at paragraphs 119 to 124, and turning first, this
23 is page 21, turning first to the call that you received
24 from Dr B on 22 January.

25 A. Yes.

1 Q. Now, you explain that Dr B told you that he had spent
2 three hours with your mother and an hour long call with
3 your father before he called you; is that right?

4 A. That's correct, yes.

5 Q. And during that call when you pressed Dr B for a
6 diagnosis he told you that your mother had borderline
7 personality disorder.

8 A. That's correct.

9 Q. But stressed this was not a mental disorder and no manic
10 or psychotic observations had been made.

11 A. That's correct.

12 Q. Your recollection of the conversation you had with Dr B
13 on 22 January is based on notes you made at the time; is
14 that right?

15 A. That's correct, yes. And also the medical records.
16 There are some notes that he wrote in the medical records
17 with regard to that.

18 Q. Yes, and so a combination of the notes you had made at
19 the time --

20 A. Yes.

21 Q. -- and also the medical records you have since seen; is
22 that right?

23 A. That's correct, yes.

24 Q. And is it your recollection that Dr B told you that
25 therapy would not work, that he did not wish to place a

1 therapist in a position where they would be manipulated
2 and that your mother's overdose was to seek attention?

3 A. That's correct.

4 Q. In terms of medication, is it right that you recall Dr B
5 telling you that medication would not work as depression
6 and anxiety medication would have a limited effect to
7 dampen symptoms and telling you that he had removed all
8 medications and would not treat your mother?

9 A. That's correct.

10 Q. Is it right that you recall Dr B saying that because
11 borderline personality disorder was not a mental health
12 disorder, your mother could not be sectioned for her own
13 safety or that of others?

14 A. That's correct.

15 Q. You describe in your statement being so shocked and
16 alarmed by what you had been told that you contacted the
17 charity MIND UK; is that right?

18 A. That's correct, yes.

19 Q. Was that following your contact with Dr B or sometime
20 thereafter?

21 A. It was following contact with Dr B, yes.

22 Q. On the same day or some days thereafter?

23 A. I can't recall exact dates, sorry.

24 Q. No problem. You explain that you understood, when you
25 did speak to MIND UK, that the use of the Mental Health

1 Act was appropriate if a person is likely to harm
2 themselves or others and that this applies to all mental
3 health conditions diagnosed in psychiatry of which
4 borderline personality disorder is one.

5 A. That's correct, that's what they told me.

6 Q. And you understood from MIND UK that there were treatment
7 for borderline personality disorder including dialectical
8 behaviour therapy and mentalisation therapy; is that
9 right?

10 A. That's correct.

11 Q. I want to turn back now to 19 January 2021 when your
12 mother had been assessed by a separate consultant
13 psychiatrist who we will be referring to as Dr A?

14 A. Yes.

15 Q. In Dr A's report, following assessment of your mother,
16 you understand that she gave your mother "a diagnosis of
17 Bipolar Affective Disorder, current episode mixed"; is
18 that right?

19 A. That's right, yes.

20 Q. And that's your understanding from having looked at the
21 report?

22 A. That's correct, yes.

23 Q. And from that report you have noted that Dr A observed
24 that your mother was, "presenting with a mixed affective
25 picture":

1 "She is irritable and pressured and manic in
2 her presentation with suicidal thoughts."

3 Is that right?

4 A. That's correct, yes.

5 Q. And speech is described in that report, as you understand
6 it, as "mildly manic"?

7 A. That's right.

8 Q. Dr A's recommendation from that report, as you understand
9 it, was for "full active treatment", and that:

10 "Admission to stabilise her mood is needed in a
11 supervised environment before community care can be
12 considered."

13 A. That's correct.

14 Q. Dr A's conclusion, and you quote this at paragraph 129 of
15 your statement, which is on page 22, was that:

16 "'There is a potential and chronic event of
17 misadventure remains given pattern of long-standing
18 risk'."

19 A. That's correct.

20 Q. Is it right that as family members you only became aware
21 of Dr A's assessment and diagnosis of your mother on 15
22 February when you were provided with correspondence
23 relating to your mother by her GP?

24 A. That's correct.

25 Q. So slightly less than a month after you had had your

1 conversation with Dr B.

2 A. Yes.

3 Q. You explain in your statement that Dr A's findings seemed
4 to you to be in complete contrast to everything that Dr B
5 and the Ruby Ward had told your family; is that right?

6 A. That's correct, yes.

7 Q. And is it right that after seeing Dr A's report your
8 sister submitted a complaint to the Patient Adviser
9 Liaison Service (PALS)?

10 A. Yes, that is correct.

11 Q. You have since seen from the records that on 22 January
12 Dr B who was conducting the assessment of your mother on
13 that date, had a phone call with Dr A who told him that
14 your mother is presenting with a mixed affective
15 presentation having been admitted following an overdose?

16 A. That's correct.

17 Q. And you also quote:

18 "Then presenting as irritable and
19 hypomanic'" -- and that it is Dr A's view that -- "'this
20 lady would be a significant risk to herself and her
21 husband and that consideration should be given to
22 detention under the Mental Health Act if she tried to
23 leave'."

24 A. That's correct.

25 Q. You note from the records that you have seen that Dr B

1 does not mention Dr A's diagnosis of bipolar affective
2 disorder and does not offer any explanation for the
3 difference between their opinions; is that right?

4 A. That's correct, yes.

5 Q. Have you ever been provided with any reason or
6 explanation as to why there was a difference between the
7 opinions of Dr A or Dr B?

8 A. No, never.

9 Q. I want to turn to some of the record keeping in this
10 regard and in terms of how your mother's mental health
11 condition is described throughout the records you have
12 seen. Is it right that you have seen her condition
13 repeatedly recorded as "manic depression"?

14 A. That's correct, yes.

15 Q. A term previously used to describe bipolar disorder?

16 A. Mm hmm.

17 Q. And that this term continues to be used in the records up
18 until her discharge on 4 March?

19 A. That's right and there's also correspondence between
20 other services, Social Services, which actually still
21 describes her condition as bipolar.

22 Q. Yes, and you have noted that manic depression is recorded
23 in the medical notes from the day of your mother's
24 discharge on 4 March.

25 A. Yes.

1 Q. And on the Essex Police Mental Health Street Triage
2 Screening form.

3 A. That's correct.

4 Q. Which you understand the ward sent to the police on 4
5 March; is that right?

6 A. That's correct, yes.

7 Q. And thereafter following your mother's overdose on 9
8 March, when she was assessed at Broomfield A&E, the HCP
9 nurse you have noted has recorded your mother's diagnosis
10 as personality disorder, not bipolar disorder or manic
11 depression?

12 A. That's correct, yes.

13 Q. Then on 10 March you have noted that when your mother was
14 discussed at the multidisciplinary team meeting, her
15 diagnosis is again listed as bipolar by the same Dr A who
16 had initially seen her on 19 January.

17 A. That's correct, yes.

18 Q. And this diagnosis of bipolar then appears in an e-mail
19 to your mother's community care co-ordinator on the same
20 afternoon.

21 A. That's correct, yes.

22 Q. You have also noted that your mother's care
23 co-ordinator's visit, which takes place on 10 March, the
24 note of that then records her diagnosis as BPD, so
25 borderline personality disorder.

1 A. That's correct, yes.

2 Q. So from the records you have seen, although on Dr B's 27
3 January ward review you note that he seems to point
4 towards personality disorder as your mother's diagnosis,
5 is it right that you understand that he doesn't formally
6 record borderline personality disorder in the medical
7 records, and only confirms that diagnosis of borderline
8 personality disorder, emotionally unstable, to the PSI
9 investigation team after your mother's death.

10 A. That's correct, yes.

11 Q. You refer in your statement to continuing diagnostic
12 confusion within the records. Your impression at the
13 time, what was your impression as to what the diagnosis
14 of your mother was while she was an in-patient at the
15 Ruby Ward?

16 A. Because it was COVID restrictions were in place and we
17 were initially told by a psychiatric nurse there would be
18 no contact with mum for at least 14 days, and obviously
19 with COVID restrictions it wasn't possible to go and
20 visit, so I made no observation whilst mum was on Ruby
21 Ward at all. I was reliant totally on what Ruby Ward was
22 actually telling us and as you pointed out before, we
23 didn't realise there was another diagnosis until I think
24 it was about 15, 16 February, a month after mum was on
25 the ward. So yeah, the confusion was, I mean I don't

1 know I'm not a medical health expert, I wouldn't know the
2 difference between bipolar, the only thing that I do know
3 is that both of those mental illnesses can present at the
4 same time. I have read somewhere, whether that is true
5 or not I don't know.

6 Q. And in terms of what you were told by the Ruby Ward did
7 you have an understanding that this may be bipolar
8 disorder, borderline personality disorder or a
9 combination or was it your understanding at this point
10 that it was borderline personality disorder?

11 A. That was our only understanding up until 15, 16 February
12 when the GP released Dr A's assessment that was done on
13 19 January, the day after mum was admitted after the
14 first overdose.

15 Q. And so the only condition that was in your mind at that
16 point was the borderline personality disorder condition.

17 A. Exactly, yes.

18 Q. I want to turn to the impact that the diagnostic
19 confusion or the diagnosis of borderline personality
20 disorder had on the treatment that your mother received.
21 As far as you were aware, was your mother given any
22 therapeutic treatment during her admission to Ruby Ward?

23 A. The only thing that I remember that mum filled in on a
24 little diary that she kept was that she received sort of
25 like exercise classes. There doesn't appear to be

1 anything and there's nothing on the medical records that
2 says she received any sort of therapy, counselling or
3 anything like that at all.

4 Q. Thank you. Now you have explained in your statement that
5 your mother had taken medication for depression
6 continuously for as long as you could remember.

7 A. Yes.

8 Q. And when your mother was taken to A&E at Broomfield
9 Hospital, following an overdose on 18 January, she was on
10 30 mg of mirtazapine; is that right?

11 A. That's correct, yes.

12 Q. You have seen in the records, you refer to Dr A
13 discontinuing your mother's mirtazapine dose on 20
14 January; is that right?

15 A. That's correct, yes.

16 Q. And the Ruby Ward drug chart, you understand, indicates
17 that she was prescribed lorazepam 0.5 mg and olanzapine
18 2.5 mg.

19 A. That's correct, yes.

20 Q. And then on 3 February you have noted in your statement
21 an entry to stop olanzapine.

22 A. That's correct, yes.

23 Q. Which you describe as particularly concerning because you
24 understand that olanzapine appears to be used to treat
25 mania or mixed episode that is part of bipolar disorder.

1 A. That's correct, yes.

2 Q. And that it must continue to be taken and withdrawn
3 gradually under medical supervision.

4 A. That's correct, yes.

5 Q. Is it right that the effectiveness of olanzapine and
6 lorazepam are not evaluated in the medical records that
7 you have seen, so whether they were working or not?

8 A. No, there's no evaluation at all.

9 Q. And is it right that it appears to you that lorazepam was
10 still being prescribed on 14 February, according to the
11 records?

12 A. Yes, I mean, obviously without seeing the drug charts,
13 but that would -- I mean, I know that by the time mum was
14 discharged, I don't know whether it was the first time
15 she did the self-discharge, but I don't think that she
16 was being treated at all with any drugs, apart from a
17 type of antihistamine that was available to her on
18 demand. All others had been withdrawn.

19 Q. Yes, and is it right that you understood that those drugs
20 had been withdrawn because your mother's discharge drug
21 chart from 4 March --

22 A. Yes.

23 Q. -- was later found in her possessions after her death?

24 A. That's right, the drug chart that she took away with her
25 from the ward did actually show that neither of those

1 drugs were shown on it.

2 Q. Is it right that as far as you were aware, there are no
3 records directing that lorazepam should be withdrawn, nor
4 any explanation given within the records for the
5 withdrawal of either drug?

6 A. No, there's nothing at all.

7 Q. I want to turn now to the topic of safeguarding and the
8 concerns that you had in relation to how the safeguarding
9 of your father was dealt with. If it assists I am
10 looking at paragraphs 131-133 of your statement which
11 start at page 22, and here you point to records you have
12 seen dating from 22 January 2021.

13 A. Mm hmm.

14 Q. Indicating that the Ruby Ward was aware of risk to your
15 father and, in particular, you refer at paragraph 132 to
16 a review carried out by staff and a support worker, which
17 records that your mother:

18 " '... is still cross with her husband, and this
19 may escalate if she goes home now'."

20 Is that right?

21 A. That's correct, yes.

22 Q. And then at paragraph 131, the paragraph above, Dr A's
23 view that:

24 " '... this lady would be a significant risk to
25 herself and her husband and that consideration should be

1 given to detention under the Mental Health Act if she
2 tried to leave'."

3 A. That's correct, yes.

4 Q. Which you understood that she had expressed in the 22
5 January call to Dr B?

6 A. That's correct, yes.

7 Q. And then at paragraph 133, you have noted your
8 understanding of Dr B's own assessment, which records
9 that threats to kill made by your mother against your
10 father, and family concerns that your father must be
11 safeguarded were recorded in that assessment; is that
12 right?

13 A. That's correct, yes.

14 Q. I want to turn now to what happened at the video call
15 Teams meeting on 9 February 2021. Is it right this was a
16 multidisciplinary team meeting on Teams attended by Dr B,
17 the ward manager, a social work manager for older adults,
18 amongst others, and to which your family was invited and
19 attended?

20 A. Yes, that is correct.

21 Q. And is it right that you were present, your sister, your
22 husband and your father?

23 A. That's correct, yes.

24 Q. You explain that you had been assured that this was to be
25 a safeguarding meeting focused on how your father could

1 be protected from your mother's aggression and violence
2 and to find a workable solution for your mother's
3 discharge; is that right?

4 A. That's correct, yes.

5 Q. You say in your statement that the written record you
6 have seen of the meeting you feel is out of context, not
7 chronological and containing falsehoods. Is that right?

8 A. That's correct, yes.

9 Q. And in particular, you mention that the history
10 observation and events you, as a family, gave concerning
11 your mother's difficult behaviour does not appear in the
12 medical record note of that meeting; is that right?

13 A. That's correct, yes.

14 Q. So when you talk about the gaps in that meeting note is
15 that principally what you are referring to, the lack of
16 mention of those aspects?

17 A. That's right yes, that our observations were not recorded
18 at all and they were quite extensive. I mean the meeting
19 went on for a little over an hour, but there was no
20 recording of what actually we said as a family at all.

21 Q. Thank you. Now in the meeting your father, is it right,
22 gave a statement, which is partially recorded in the
23 medical records but not completely; is that right?

24 A. That's correct, yes.

25 Q. And in that he described what he had been through trying

1 to cope with your mother's crisis, and he made it clear
2 he could no longer cope and broke down and cried as he
3 recalled the abuse that he had experienced; is that
4 right?

5 A. That's correct, yes.

6 Q. And having seen that record, is it your view that it
7 doesn't reflect that aspect of what was said in the
8 meeting?

9 A. Not at all. I mean, yes, what dad said wasn't taken on
10 board at all.

11 Q. In the medical records of that meeting you have set out
12 that Dr B outlined that your mother had developed a
13 personality where she gets defensive if people question
14 her and can become aggressive if people don't agree:

15 "Most of these aggressive episodes are limited
16 to their family as they can control these urges and that
17 your mother can manipulate the situation."

18 Is that right?

19 A. That's what he recorded, yes.

20 Q. Is that consistent with what you recall him saying at the
21 meeting?

22 A. It is.

23 Q. Now, although Dr B, as you have recorded it, recognised
24 these behaviours in the meeting, you have described
25 finding that he made no suggestions as to how to manage

1 them or support your family to do so; is that right?

2 A. That's correct, yes.

3 Q. And you felt, as you have set out in your statement, that
4 he became very defensive at any suggestion that the risk
5 to your father must be considered and resolved and proper
6 assurances given that your mother was well enough and
7 sufficiently supported to be safely discharged.

8 A. He gave no assurances and Social Services also were very
9 worried about the fact that dad's safeguarding was not
10 being considered properly by the ward.

11 Q. And is it right that the social work manager stepped in
12 during the meeting to explain that safeguarding had been
13 raised, and was presently with EPUT and that she would
14 look into that?

15 A. That's correct, yes, she did.

16 Q. What was your understanding as to the stage safeguarding
17 investigation had reached on that point on 9 February?

18 A. As a family, we were given no information about EPUT
19 safeguarding, what was involved and who would be doing
20 it. Even at that stage at that meeting no one knew who
21 was doing the safeguarding investigation on behalf of
22 EPUT at all, and the culmination at the end of meeting
23 was that the social worker was going to look into that
24 and find out who was doing it and at what stage it was.

25 Q. Was it your impression that Social Services were taking

1 on responsibility for safeguarding from that point on?

2 A. It seemed like that because we had, the family including
3 my father, had a meeting with Social Services afterwards
4 and she did actually say that she would start to get the
5 police involved under the DASH process, as a means to
6 safeguard my father, yes.

7 Q. And in terms of the EPUT investigation, were you given
8 any point of contact in terms of the safeguarding
9 investigation or who you should speak to about it?

10 A. Not at all.

11 Q. You explained in your statement that during the meeting
12 Dr B confirmed that he would allow your mother to leave
13 the ward, and saw no reason for her not to go home as she
14 co-owned the house with your father.

15 A. That's correct, yes.

16 THE CHAIR: Just to be clear, the impression you got was that
17 Social Services were going to take over responsibility
18 for the safeguarding of your father?

19 A. It did seem like that, yes.

20 THE CHAIR: Notwithstanding that EPUT were going to go on
21 doing their own investigations, is that right?

22 A. I don't know what they did or spoke about between
23 themselves, but it did appear very disjointed, like I
24 said we didn't know anything about the EPUT investigation
25 at all. We were never given any details.

1 THE CHAIR: Thank you.

2 MS LLOYD-OWEN: So when you mentioned DASH, was that your
3 understanding in terms of other avenues effectively for
4 your father to be safeguarded, so involving social
5 services on the other side of things?

6 A. That's correct, it was sort of an added layer. I don't
7 know why Social Services decided to go down that route.
8 I don't know whether they felt that EPUT wasn't doing
9 enough to safeguard dad. I am not sure what their
10 reasoning behind that was, but that's what we were told
11 by Social Services. That was the direction they were
12 going to point my father towards to try to keep himself
13 safe.

14 Q. Is it right that you recall that at that meeting the
15 social work manager made the point she felt sending your
16 mother home would be dangerous, and that in her
17 experience this would allow aggressive behaviours to be
18 reinforced?

19 A. Yes, she said that to us. I think it was not actually at
20 the meeting, but it was the meeting we had with her
21 afterwards because she said she had experienced this
22 particular situation before, and she said the danger to
23 the family was enough to warrant putting safeguarding in
24 place for dad.

25 Q. Thank you, and is it right that there's of course the

1 medical record of that meeting, but also you took your
2 own note of that meeting?

3 A. I did, yes.

4 Q. At the conclusion of that meeting, as far as you
5 understood it, was there a solution to the issue of
6 safeguarding your father or accommodation for your mother
7 if she self-discharged?

8 A. Not at all.

9 Q. So when you left that meeting, what was your
10 understanding as to what was going to happen to your
11 mother at that point?

12 A. We didn't know at all. We were just deeply concerned.
13 We had no idea. It was out of our hands. It was -- we
14 were desperate to try and keep mum safe, but it didn't
15 appear that anyone wanted to listen.

16 Q. You have now seen your mother's care plan from 14
17 February, so some five days on, in which you record, and
18 this is at paragraph 197, you record under "Risk and
19 Management" refers to risk of OD (overdose) when feeling
20 neglected, along with self-neglect, vulnerability,
21 emotional state. It also records and this is the at
22 paragraph 198:

23 "I understand that until the safeguard is
24 investigated and we are aware of the outcome, I will
25 remain here as an informal patient until it is resolved."

1 A. That is correct.

2 Q. This is the extract you have put into your statement:

3 "I am fully aware if I attempt to leave the
4 ward at present, due to the ongoing safeguard open, that
5 police will be informed and I will potentially be held
6 under section."

7 A. Yes.

8 Q. That's obviously from the medical records which you have
9 seen subsequently.

10 A. Yes.

11 Q. Was this communication and the plan communicated to you
12 at this stage?

13 A. Not at all.

14 Q. Were you aware some five days on from meeting or updated
15 in relation to what the plan was in relation to your
16 mother?

17 A. Not at all.

18 Q. I want to turn to the next day, the 15 February, and
19 calls made to your family. You describe, and this is at
20 paragraph 184 and 185 of your statement, here you
21 describe Ruby Ward staff calling your father, insisting
22 that he return your mother's belongings, including her
23 keys, which had been provided to you when she was
24 admitted and you had passed on to him so that she could
25 return home; is that right?

1 A. That's correct, yes.

2 Q. And when your father refused, you understand that two
3 further members of staff then spoke to him threatening
4 him with police action?

5 A. That's correct, yes.

6 Q. After Ruby Ward called your father, you recall that he
7 called you in floods of tears. Is that right?

8 A. He did, yes.

9 Q. You received a missed call and when you called back, you
10 were confronted with a loudspeaker call involving three
11 doctors and a matron from the Ruby Ward; is that right?

12 A. That's correct, yes.

13 Q. You then also faced threats of police action; is that
14 right?

15 A. I did, yes.

16 Q. Is it right that at the end of the 15 February call you
17 made clear that you should be contacted first rather than
18 your father?

19 A. I did, yes, because dad was just too upset by the
20 bullying that they were clearly carrying out.

21 Q. Yes, and you describe in the statement the call that you
22 had as very heated and confrontational. Is there
23 anything else that you would want to add in terms of the
24 interaction that you had with staff on this phone call?

25 A. It wasn't what I would have expected from a staff,

1 professional staff. I just would never have expected
2 them to have behaved like that, and the thing that upset
3 me more when I read the medical records, it was never
4 recorded that they phoned my father first and left him in
5 floods of tears. They only recorded my telephone
6 conversation with them and only very briefly.

7 Q. So there was a brief record of your call but no record --

8 A. No record.

9 Q. -- as far as you could see --

10 A. That's right, yes.

11 Q. -- of the call your father had?

12 A. Yes.

13 Q. And is it right that at this point the EPUT safeguarding
14 investigation was still ongoing?

15 A. Yes, my father asked in his phone call at what point the
16 safeguarding was. I also asked, and I was told that it
17 hadn't been completed. So I said unless that's done, we
18 can't have mum home because we can't cope with and keep
19 her safe.

20 Q. Is it right that, in fact, the EPUT safeguarding
21 investigation remained open until your mother's death?

22 A. It did.

23 Q. After your mother's death, in the context of a PSI
24 investigation report, is it right that you were told that
25 there were staff shortages in safeguarding roles?

1 A. That is correct, yes, because once I got sight of the
2 medical records I realised that the safeguarding expert
3 that was recruited for the PSI had also been involved in
4 mum's care, and was the safeguarding expert called in by
5 EPUT. So there was a conflict there, and I picked up the
6 PSI team on this, and they apologised and said that the
7 team leader should have checked, but he also said that
8 there wasn't enough safeguarding staff, he said, so he
9 would have found it very difficult to find somebody who
10 wasn't involved in your mum's care.

11 Q. Were you told whether or not those shortages may have
12 impacted on the time taken to undertake safeguarding in
13 your mother's case?

14 A. Not at all.

15 Q. Now from the records you have seen, turning back to the
16 February, it appears that Social Services called Ruby
17 Ward on 18 February 2021 saying that safeguarding was
18 raised and if your mother entered the home address, she
19 was at risk of arrest?

20 A. That's correct, yes, because by this point Essex Police
21 had interviewed my father and myself, and it had been
22 decided that they would put a red flag on dad's telephone
23 number, and that they would attend to protect him from
24 domestic abuse under blue light. That was the agreement
25 that the police gave. That's the protection that they

1 gave dad, yes.

2 Q. And if you turn to paragraph 94, which is at page 17 of
3 your statement, you refer there to your father later
4 admitting to Essex Police and Social Services that he had
5 contemplated suicide himself feeling that he had no way
6 out. Is that a reference to that meeting that had been
7 had between the police and your father?

8 A. It was, yes. I mean this is the first that I knew --
9 well, I don't say it was the first I knew of it. There
10 was an incident on Boxing Day, in January, where mum said
11 that dad had been talking about wanting to take his life
12 because he couldn't cope any more. So actually it wasn't
13 the first time that I had heard, but it was the first
14 time that I had heard but it was the first time that he
15 had actually admitted to the services that that's how he
16 had felt because he could no longer cope with mum and her
17 behaviour. He couldn't keep her safe.

18 Q. And so as far as you are aware, this meeting which is
19 referred to at paragraph 94 of your statement, was the
20 first time that your father expressed that level of need
21 for support to services?

22 A. That's correct, yes.

23 Q. And that happened, that meeting that's described in
24 paragraph 94 happened before 18 February. Is that right?

25 A. Yes, I believe it happened on 17 February, I did look it

1 up.

2 Q. Thank you. On 22 February you describe another call to
3 your father from someone on Ruby Ward, insisting that he
4 agree to your mother coming home and again your father
5 ringing you in tears after the call; is that right?

6 A. That's correct, yes.

7 Q. And you have expressed your view that this was bullying
8 on the part of the ward. You also explain in your
9 statement that at this stage your father had come to the
10 realisation that he could no longer live with your mother
11 if there was no hope of treatment or any clinical intent
12 to resolve her mental ill health; is that right?

13 A. That's correct, yes.

14 Q. And you say that he was effectively left with no
15 alternative but to take legal action.

16 A. Yes, this is what he was advised by Social Services. It
17 was the only route that he had to keep himself safe and
18 when he did consult a solicitor, they said the only thing
19 he could do was a non-molestation order and to divorce my
20 mum.

21 Q. Yes, and those were -- that is the legal action that you
22 were talking about in your statement there; is that
23 right?

24 A. Yes, that is correct, yes.

25 Q. I want to turn, and we may not complete this next action

1 section before a break, but I want to turn to the topic
2 and your concerns in relation to your mother's discharge.

3 A. Yes.

4 Q. Firstly, is it right that your mother attempted to
5 discharge herself from the ward on 20 February as you
6 understand it?

7 A. That's correct, yes.

8 Q. And as you understand the records, ward staff followed
9 the plan of calling the police to attend and assist.

10 A. That's correct, yes.

11 Q. And again this is paragraphs 216-220 of your statement
12 that you deal with this aspect and what took place.

13 Which is at page 38 of your statement. You understand
14 that the on-call doctor had not seen your mother before
15 she discharged herself from the ward and staff called
16 police; is that right?

17 A. Yes, that is correct, yes.

18 Q. And when police were called, you understand that they
19 refused to attend and confirmed to the ward that this was
20 a matter for Social Services rather than the police?

21 A. That's correct because both myself and my sister did
22 actually receive out of the blue telephone calls from
23 Essex Police to this effect, saying that they would not
24 attend and that it was a Social Services and a
25 duty-of-care issue for the ward.

1 Q. So contact had been made by the Ruby Ward, as you
2 understood it, to the police.

3 A. Yes.

4 Q. And contact had been made with you.

5 A. Yes.

6 Q. And that's how you became aware of it.

7 A. That's correct, yes.

8 Q. And at this point, are you aware whether the ward or the
9 police called Social Services given that the suggestion
10 was Social Services were the right service?

11 A. We did not know, and I can't remember who it was, I can't
12 remember what it was myself or my sister I have a feeling
13 it was me, I phoned Social Services after the police had
14 talked to us, asking them and they said that they
15 couldn't act unless Ruby Ward or the police asked them to
16 act.

17 Q. You understand from the records that the on-call
18 registrar managed to persuade your mother to stay on the
19 ward.

20 A. He did, yes.

21 Q. And from what you have seen, is it right that that
22 on-call registrar instructed the nursing staff should
23 utilise section 5(4) power under the Mental Health Act,
24 enabling them to detain your mother for up to six hours,
25 in order to inform the on-call doctor, who then used the

1 section 5(2) power to detain for up to 72 hours; is that
2 right?

3 A. Yes that was his recommendation, yes.

4 Q. And from what you have seen, it appears that a DATIX
5 incident report was made.

6 A. That's correct, yes.

7 Q. And from your reading, the on-call doctor has recorded
8 that it will not be safe for your mother to leave the
9 ward without a safe discharge plan, and that he will
10 discuss the discharge plan with the ward team and
11 consultant.

12 A. That's correct, yes.

13 Q. But you have not seen a record to indicate that this
14 happened; is that right?

15 A. No, there's nothing on the medical records that shows
16 that that ever took place.

17 Q. Is it right that you do not know whether either of the
18 on-call doctors discussed a safe discharge plan with Dr B
19 and the ward team or whether any Mental Health Act powers
20 were used and what the outcome was of the DATIX report?

21 A. We don't know anything, no, not at all.

22 Q. From the records you have seen, is it right that it
23 appears that the discharge plan from 20 February was not
24 reviewed?

25 A. It doesn't look like it, no.

1 Q. Now, on 4 March your mother discharged herself from Ruby
2 Ward. I am conscious that we are due a break in the next
3 few minutes.

4 I wonder, Chair, whether we should take a break
5 slightly earlier for 15 minutes and then return and
6 continue at that stage?

7 THE CHAIR: I think that sounds sensible, yes.

8 (2.56 pm)

9 (Break)

10 (3.14 pm)

11 MS LLOYD-OWEN: Jane, before you start can I just remind you
12 to try and keep your voice as loud as you can.

13 A. Okay, I will try.

14 Q. I appreciate it can be very difficult but just we just
15 want to make sure the transcript captures everything you
16 are saying.

17 A. Thank you.

18 Q. We have moved the microphone so that might make things a
19 little better and I may remind you if your voice drops
20 again.

21 A. Yes, thank you.

22 Q. We were just about to turn to 4 March, when your mother
23 discharged herself from Ruby Ward. I want to briefly
24 just draw your attention to some of the correspondence
25 you refer to. You refer to an e-mail from that day, 4

1 March, from a senior social work practitioner from the
2 mental health team to an RMN, so a registered mental
3 health nurse, raising concerns around care and
4 safeguarding around the imminent discharge, and
5 highlighting a problem regarding who was responsible for
6 arranging accommodation and noting several documents
7 being missing, for example, the care needs assessment and
8 occupational therapy assessment.

9 A. That's correct, yes.

10 Q. At this point, on the morning of 4 March, when your
11 mother returned to the address, were you aware that she
12 was due to be discharged.

13 A. Not at all.

14 Q. Had anything been communicated to you or your father in
15 the days leading up to about discharge being imminent?

16 A. Not at all.

17 Q. Is it right that on 3 March there had been calls from
18 your mother to family members?

19 A. Yes.

20 Q. And are you able to say something about how many, what
21 calls you received?

22 A. There were a number of calls to my nephews, mum's
23 grandchildren, to me, to my sister and also to my father.

24 My father initially answered a telephone call to mum,

25 where she said that she was coming home and dad tried to

1 speak with her about the fact that there was safeguarding
2 that was still not being resolved. Mum became very
3 agitated so dad didn't continue the call. My sister
4 spoke with my mum for a short period of time, just
5 basically to try and find out whether she was safe, and
6 where she was and she confirmed she was still on the ward
7 and that she was safe. But nobody from the ward
8 contacted us at all. Dad was very upset because mum said
9 that she was coming home. I went over there that evening
10 and spent the evening with him because he was really
11 quite frightened. But no, we were never told by the ward
12 or anybody else that was mum was imminently to come home.
13 My eldest nephew, he was at work at the time, and he got
14 the missed calls from mum, and he phoned the ward and
15 spoke with the ward manager and said, "You know we don't
16 know anything about, you know, my grandmother coming home
17 and you are upsetting her husband and is it safe to send
18 her home?" He was asking lots of questions. But the
19 conversation was abruptly shut down because the ward
20 manager just put the phone down on him. So we weren't to
21 know that imminently mum was to come home at all. We
22 weren't notified by the ward at all.

23 Q. Is it right that at this point your mother didn't have a
24 mobile phone, and so you understand that the phone calls
25 must have been made from a phone on the ward, as it were?

1 A. Yes.

2 Q. With permission?

3 A. The medical records actually confirm that the calls were
4 made from the ward office phone.

5 Q. Thank you. Now, you refer in your statement to e-mails
6 from 15 March, sometime thereafter, but from Social
7 Services to Ruby Ward and the ward manager, indicating
8 the possibility of inappropriate discharge and stating
9 that there was no discharge planning. Ward staff, you
10 say, you have seen records in relation to ward staff
11 seeming not to know that they had to follow a duty to
12 refer referral to the local authority, and that ward
13 staff did not inform the older adult social care team on
14 the day of discharge, so they were unable to fulfil their
15 duties including wellbeing; is that right?

16 A. That's correct, yes.

17 Q. Now, is it right that you have since learned, it is your
18 understanding, that from the PSI investigation report
19 that the discharge co-ordinator's job was vacant on Ruby
20 Ward at the time of your mother's discharge?

21 A. Yes, it was.

22 Q. There is, you have referred to an entry in the medical
23 records from the care co-ordinator to suggest that your
24 family had been contacted by the ward. Is it your
25 evidence that family members were not contacted on that

1 day and that the record of a reaction from you stating,
2 "Family dynamic going on already", is entirely false?

3 A. That's fabricated, yes. No one in the family was rung at
4 all.

5 Q. And as far as you were aware, no steps were taken to
6 communicate the likely discharge to you, your father or
7 any other family member?

8 A. No one was contacted at all.

9 Q. In terms of what that discharge was going to look like,
10 from the records you have seen, is it right that you
11 understand in terms of community support for your mother
12 on discharge, this appears to have consisted only of a
13 check by the community care co-ordinator within 48 hours
14 and a seven day follow-up?

15 A. That's correct, yes.

16 Q. This is your understanding from the records, but at any
17 stage before or indeed after your mother's discharge,
18 were you made aware of any care plan outlining the
19 support that she would receive when she was in the
20 community?

21 A. Not at all.

22 Q. I want to turn now to your mother's arrival at the home
23 address and that is set out at paragraphs 243-246 of your
24 statement, page 43 onwards. On 4 March, your mother
25 arrived by taxi at the home she had previously shared

1 with your father; is that right?

2 A. That's correct, yes.

3 Q. And according to the PSI investigation report and the
4 medical records you understand that your mother was
5 escorted by a member of ward staff to the address in the
6 taxi but that they did not get out of the taxi and your
7 mother was left to gain access to the property without
8 keys or a telephone alone?

9 A. That's correct, yes, my father didn't observe anybody
10 else get out of the taxi other than the taxi driver and
11 my mother.

12 Q. The driver got out to take your mother's bags?

13 A. Bags, that's correct, yes, but he never saw anybody else.

14 Q. You understand, is this right, that your mother knocked
15 on the window to ask your father to let her in, and as
16 advised by police and in accordance with the red flag
17 alert your father refused entry and immediately called
18 the police?

19 A. That's correct, yes.

20 Q. They arrived with blue lights as anticipated; is that
21 right?

22 A. That's correct, yes.

23 Q. Is it right your father then called you and you arrived
24 about half an hour later?

25 A. That's correct, yes.

1 Q. On this occasion of police attendance what happened once
2 you arrived at the address?

3 A. Mum was sitting in the police car with a special
4 constable. I came into the property. Dad was immensely
5 distressed, telling me that they're going to let mum into
6 the house, she will hurt me and he was really very, very
7 distressed. One of the main police -- there was a police
8 constable and three special police constables.

9 Q. Just to be clear this is 4 March?

10 A. 4 March.

11 Q. When she is discharged?

12 A. Ah sorry, no, I beg your pardon.

13 Q. Not to worry, there is an incident on 13 March that we
14 will come to.

15 A. That's right, sorry, yes, I am getting confused with the
16 two. Thank you for correcting me. Yes, on the 4th, yes,
17 police officers were there, there was two female police
18 officers that came into the property, they assured my
19 father that they would not let mum into the property.
20 She was being cared for by street triage police officers
21 at a neighbour's property and it was likely that they
22 would find her accommodation and that dad wasn't to
23 worry. Police officers came and said that they had
24 arranged temporary accommodation for mum, took her to a
25 place of safety and dad provided money for a hotel

1 overnight. Yes, that was the culmination of that
2 incident. We were treated with respect. They understood
3 the dangers to my father and although we were immensely
4 distressed that mum had been discharged and we didn't
5 know that she was about to be discharged, and we were
6 frantic with worry for her wellbeing, yes, at least the
7 police did appear to do the right thing on that occasion.

8 Q. Is it right that whilst this was going on officers
9 advised you to contact Social Services to verify whether
10 accommodation for your mother had been arranged?

11 A. That's correct, yes, I did ring them up in the presence
12 of two female police officers to be told that the
13 on-duty, on-call social worker didn't know anything about
14 it and they hadn't been informed that mum had been
15 discharged.

16 Q. So as you understood it at this point there had been no
17 notice to Social Services either in terms of the
18 discharge?

19 A. Yes, because it was, well, I believe it was their
20 responsibility to arrange accommodation until the
21 safeguarding was organised, so, you know, I don't know.

22 Q. And on this occasion the Essex Police Street Triage
23 officers arranged emergency accommodation; is that right?

24 A. That's correct, yes.

25 Q. And the following day on 5 March, you contacted Social

1 Services and spoke to not the duty team but somebody
2 else.

3 A. Mm hmm.

4 Q. And you say in your statement that they seemed equally
5 alarmed and confused by the Ruby Ward's actions in
6 allowing self-discharge without supported accommodation;
7 is that right?

8 A. That's correct, yes.

9 Q. And at this point is it your understanding that Social
10 Services collected your mother from the overnight
11 emergency accommodation and arranged temporary housing
12 for her?

13 A. They did, yes.

14 Q. You have explained that you spoke to the duty social
15 worker the day preceding and to the police. Are you able
16 to say whether the information you had given to the duty
17 social worker, or indeed the police, had been passed on
18 to Social Services that you spoke to on the 5th or indeed
19 the Ruby Ward?

20 A. I have no idea. I mean they never said anything to us,
21 so I don't know whether that happened or not.

22 Q. Thank you. In terms of the communication between the
23 different agencies and services, following your mother's
24 discharge you describe in your statement there being no
25 co-ordinated care in place, with all necessary support

1 services disjointed leaving your mother vulnerable and
2 your family extremely worried. Was that your experience
3 throughout this period?

4 A. Yes, definitely, yes, terrified, she was so vulnerable.

5 Q. In your statement you, in particular, explained that the
6 Ruby Ward nurse was unable to conduct the required 24
7 hour follow-up call because your mother did not have a
8 mobile phone. Is that your understanding?

9 A. Yes, that is correct.

10 Q. And as far as you have seen from the records, is there
11 any indication that consideration was given to how your
12 mother would be contacted once she left the Ruby Ward,
13 given that it was anticipated that she may be refused
14 entry to the family home?

15 A. Nothing was put in place at all, no means of
16 communication, no accommodation, nothing was put in place
17 at all.

18 Q. Is it right that you understand that your mother's
19 community care co-ordinator failed to reach your mother
20 to conduct a 48 hour post discharge check and instead,
21 therefore, planned to visit on 8 March, four days after
22 her discharge, but that in fact even this visit did not
23 happen?

24 A. That's correct because that's what it says in the medical
25 records.

1 Q. Thank you. I want to turn now to focus on the sequence
2 of events following your mother's overdose on 9 March
3 about which you raise considerable concerns.

4 THE CHAIR: I am a bit confused. You said earlier that there
5 had been evidence that there was no care co-ordinator at
6 the time, that at the time of this discharge the role was
7 vacant.

8 A. That was the discharge co-ordinator.

9 THE CHAIR: I am so sorry, the discharge co-ordinator, not the
10 care co-ordinator. I am very, very sorry, forgive me.

11 A. The discharge co-ordinator.

12 MS LLOYD-OWEN: Thank you. Turning to 9 March, on the
13 afternoon of 9 March is it right that you received a call
14 from your mother's social worker informing you that your
15 mother had told her care co-ordinator that she had
16 overdosed?

17 A. That's correct, yes.

18 Q. And he had called an ambulance for her?

19 A. He had, yes.

20 Q. Is it right that you were then called by A&E staff at
21 Broomfield that evening?

22 A. Yes, that's correct.

23 Q. Seeking background information?

24 A. That's correct, yes.

25 Q. Can you recall what information you were asked to share,

1 for example, did they ask you about your mother's mental
2 health history, her recent in-patient admission, her
3 discharge, your concerns, what information were you asked
4 to share?

5 A. I was asked about the recent problems with mum's mental
6 health. Sorry, can you ask the question again? I have
7 lost my train of thought.

8 Q. Just to understand when you say "seeking background
9 information", what sort of information were you asked
10 about?

11 A. Yes. I was asked about mum's recent in-patient, also
12 about her recent mental health crisis, which I relayed in
13 quite a lot of depth. I pleaded with whoever it was I
14 was speaking to at A&E that mum was very, very unwell and
15 she was very, very vulnerable, she was only in temporary
16 accommodation because of safeguarding issues with my
17 father and I asked if somebody would please, please help
18 her, treat her.

19 Q. Yes, and is it right that in fact you received no updates
20 in relation to whether your mother had been admitted or
21 otherwise that evening?

22 A. Yes, the gentleman that I spoke to he said that they
23 would get Mental Health Services in to do an assessment
24 but I have no idea what that assessment -- what happened
25 or the results of that assessment. When we had a

1 complaint meeting after the PSI with an EPUT
2 representative, we were told that A&E records are kept
3 separate to mum's medical records and that they would ask
4 for them to be -- so that we could see them, but I never
5 have seen those A&E records. That assessment doesn't
6 actually feature in her medical records at all, so I'm
7 not quite sure why, at 11 o'clock at night mum was put in
8 a taxi and sent back to her accommodation when I had been
9 assured that Mental Health would be called in and
10 reassess her and if she needed in-patient care, she would
11 be given it.

12 Q. So you understand that your mother was returned to her
13 temporary accommodation at 11 pm?

14 A. That's right.

15 Q. And no contact, as you understand, was sought to be made
16 with you or any other family member?

17 A. That's correct, yes, not even Social Services either.
18 They didn't know about it until I phoned them and told
19 them.

20 Q. Given that you were not notified of your mother's
21 discharge from A&E, is it right to say you were not
22 provided with any documentation or guidance on how to
23 support her in the community after this admission?

24 A. That's correct, yes.

25 Q. Were you given any guidance in relation to a discharge or

1 crisis plan at any point?

2 A. No, never.

3 Q. Now, is it right that the following morning, on 10 March,
4 when you hadn't heard anything, you contacted the
5 hospital and found out that your mother had been
6 discharged?

7 A. That's correct, that's how I found out.

8 Q. And you contacted Social Services at that point and they
9 notified you that they had not known either.

10 A. That's correct, yes.

11 Q. From what you have seen of your mother's records, it
12 appears that your mother was discussed at a
13 multidisciplinary team meeting on that morning on 10
14 March; is that right?

15 A. That's correct, yes.

16 Q. With concerns raised regarding diagnosis, isolation and
17 overdose risk.

18 A. That's correct, yes.

19 Q. And is it your understanding that an urgent face-to-face
20 consultation was requested, with another doctor planned
21 to contact your mother?

22 A. That's correct, yes.

23 Q. And is it your understanding that an HCP nurse appears to
24 have then left a message for your mother but not to have
25 made direct contact?

1 A. That's correct, yes, that's what it says in the medical
2 records, yes.

3 Q. With regards to your mother's access to a mobile phone,
4 you explain at paragraphs 261-266 that your mother had no
5 working mobile phone at the time of her discharge; is
6 that right?

7 A. That's correct, yes.

8 Q. And even when given one by her social worker you say that
9 she struggled to operate it; is that right?

10 A. That's correct, yes.

11 Q. And what was your view in terms of the impact that had on
12 safety plans?

13 A. Well, there was even a recording in the medical records
14 where the community care co-ordinator gave mum a 111
15 number for her to use if she was in crisis, but of course
16 how could she make a call? She couldn't work the mobile
17 phone that she did have. She was staying in temporary
18 accommodation, there was a land line there but I don't
19 know whether that was for the people living there to use
20 or whether it was for the people running the
21 accommodation. I really don't know, but there was no way
22 of contacting my mother at this point. The social
23 worker, mum's social worker raised this with us as a
24 family, saying that she was struggling to get mum to
25 understand how to operate the mobile phone.

1 Q. And so would it be fair to say that in your view it
2 was -- the offer of the crisis number was ineffective
3 because of the difficulties your mother had with the
4 phone?

5 A. Exactly, exactly.

6 Q. Now on the morning of 10 March your mother's community
7 care co-ordinator then confirmed that he was to visit
8 your mother and to refer her to gatekeeping, is that your
9 understanding?

10 A. That's what is written in the medical records, yes.

11 Q. Your mother's community care co-ordinator, you
12 understand, in his notes following his 10 March visit
13 recorded that your mother was tearful, low in mood,
14 expressed intrusive thoughts and denied plans of suicide
15 but was clearly vulnerable.

16 A. Yes.

17 Q. And on 11 March, as you understand it, a
18 multidisciplinary team zoning meeting assessed your
19 mother's risk level as red, which you understand to mean
20 in crisis.

21 A. I would have thought so, yes.

22 Q. Your mother's care co-ordinator then contacted her on 11
23 March, again having to call the hotel as your mother
24 still could not answer the phone, and gave, I believe it
25 may be the call you described in relation to the crisis

1 line; is that right?

2 A. That's correct, yes.

3 Q. On 12 March, it is your understanding, is it, that the
4 care co-ordinator visited your mother and told her that
5 she was being referred to Home First?

6 A. That's correct, yes.

7 Q. But when your mother refused visits from the Home
8 Treatment Team and denied suicidal ideation, no acute
9 risk is recorded and the gatekeeping assessment was
10 withdrawn.

11 A. That's correct, yes.

12 Q. You say in your statement that it appeared to you that
13 your mother was withdrawing from the support.

14 A. Definitely, what I read in the medical reports,
15 definitely, yes, and what the social workers had been
16 telling us.

17 Q. And have you seen anything in the records to indicate
18 that the care co-ordinator was concerned about this
19 withdrawal from support?

20 A. Nothing that I can recall.

21 Q. I want to turn now to an incident on 13 March which we
22 began to speak about earlier?

23 A. Sorry, yes.

24 Q. And it is another interaction with the police; is that
25 right?

1 A. It is yes, correct.

2 Q. So on 13 March, your father, yourself, your mother and
3 Essex Police are involved in an incident when your mother
4 attended the address where she formerly lived with your
5 father and where your father was living at the time; is
6 that right?

7 A. That's correct, yes.

8 Q. The police arrived with blue lights in line with the
9 marker procedure deployed on 4 March, but is it right
10 that on this occasion rather than persuading your mother
11 to return to her temporary accommodation, you say they
12 left your mother on the porch outside the house; is that
13 right?

14 A. That's correct, yes.

15 Q. Is it right that your mother then tried to break into the
16 property?

17 A. Yes, that's correct, yes.

18 Q. Are you able to say more about what took place during
19 this incident?

20 A. When mum tried to break in?

21 Q. Yes. So is it right that she tried to break into
22 property and was verbally abusive at the time?

23 A. She was, yes. She went to a shed in the garden and she
24 got a brick, a shovel and a pair of secateurs. She was
25 shouting and she was banging the side of the house and

1 the windows with the shovel. She was prising the
2 woodwork away from the glass. She did considerable
3 damage to the window. She managed to get a fanlight open
4 and reached through and got a blind and cut the blind
5 with the secateurs that she had in her hand. At this
6 point my sister, who was present, she telephoned the
7 police and said that mum was trying to get into the house
8 and being verbally abusive and the police did turn up
9 again under blue lights.

10 Q. And so is it right --

11 THE CHAIR: Sorry, they had already come, had they, and gone
12 away.

13 A. Yes, and left mum there.

14 THE CHAIR: Just outside?

15 A. Outside in the porch, yes. It is an open porch, it's not
16 a -- just an open porch outside.

17 MS LLOYD-OWEN: So is it the same officers, different officers
18 that arrive?

19 A. It was exactly the same officers.

20 Q. And so you were just about to tell us the officer
21 returned and what happened at that point?

22 A. I showed her a short video that I had taken of mum trying
23 to get into the window and the damage that she had done.

24 The police officer disregarded it and said, "It's your
25 mother's house, she's allowed to damage it." She said to

1 me, "You should have let your mum in, it's her house."

2 And I said, "But would you have let them in if they were
3 wielding a shovel and secateurs and a brick, you know, we
4 were terrified", and she didn't say anything to that.

5 Q. And at this point is it right that you called Social
6 Services in the presence of your father and the police
7 officer?

8 A. Yes, at some point during this, and I can't actually
9 remember whether it was the first time they came or the
10 second time, but at some point someone phoned Social
11 Services, I can't remember if it was me, my sister or the
12 police, but a telephone call with the on-call social
13 services was on loudspeaker and the police officer said,
14 you know, sort of outlined the situation and said that
15 she felt that mum should have access to the house and the
16 social worker made it plain that, yes, on a legal basis
17 mum had a right to be in the property but if there was a
18 safeguarding issue, especially one that hadn't been
19 resolved, that the police shouldn't allow mum into the
20 property if dad was in danger. The police officer went
21 on to disregard this, was insistent that mum came into
22 the property and dad became most upset. She didn't
23 pursue this, but yes -- sorry.

24 Q. No, please take your time. There's water there if it
25 helps.

1 A. Yes, thank you.

2 Q. You describe in your statement this incident as long,
3 protracted, terrifying and traumatic.

4 A. Yes.

5 Q. And you explain that it lasted approximately four hours;
6 is that right?

7 A. It did, yes.

8 Q. At some point your mother accused you and your father of
9 stealing her bank card, money and keys, is that right?

10 A. This was the number of items that the hospital had
11 released to us because they had no safe storage for it,
12 so there was a number of items that were released to me,
13 I signed for them, and the nurse who gave them over to me
14 at Ruby Ward also signed and mum had also signed a piece
15 of paper, although I didn't do it in the presence of mum,
16 she had signed what I recognised to be her signature
17 giving me permission to take these items. I then took
18 them home and gave them to my father for safekeeping. So
19 I don't know, theoretically, I hadn't stolen them at all,
20 they had been given to me for safekeeping.

21 Q. And is it right that you, both you and your father were
22 then arrested on suspicion of theft and taken to Basildon
23 Police Station?

24 A. Yes. First of all, body worn camera footage shows that
25 the officer says that myself and my father must leave the

1 property for our own safety or she would arrest us for
2 our own safety. My father refused to leave. He was 93
3 years of age, so I opted to stay with him and not leave
4 the property, to remain with him. And then the tack was
5 changed where we were then told that we would be arrested
6 on suspicion of theft, so obviously that's what happened
7 and we ended up at Basildon Police Station. On our
8 arrival, police records actually show that the sergeant
9 wouldn't detain either me or my father because it is
10 recorded that certain, I think, something called PACE was
11 not met with our arrests. So we were sent home straight
12 away, police officers took myself and my father to my
13 home and then we both gave statements under caution.

14 Q. And at this point you are therefore, you and your father
15 are at your home.

16 A. Yes.

17 Q. And as you understand it, your mother is then at the
18 address and she remains there until her death; is that
19 right?

20 A. That's correct, yes.

21 Q. And as far as you are aware, following this -- this is
22 the 13th, the Saturday?

23 A. Yes.

24 Q. On the 13th, the Saturday, or on the Sunday are you aware
25 of whether the officers in attendance or indeed the

1 social worker that you spoke to on the phone had spoken
2 to Ruby Ward or your mother's care co-ordinator or called
3 Social Services, as far as you are aware, from the
4 records you have seen or what you know, had there been
5 any communication of what happened?

6 A. There's nothing in the medical records that shows that
7 that happened and myself and the family weren't told that
8 Social Services had been told where mum was now residing.

9 Q. And again on the Monday morning, so 15 March, you called
10 Social Services, who you describe expressing shock at not
11 having been informed by police; is that right?

12 A. Exactly, yes.

13 Q. And you understand from the records that Social Services
14 then e-mailed the ward manager and matron from Ruby Ward
15 requesting an urgent update on your father's safeguarding
16 enquiry, with Social Services confirming that a serious
17 incident had occurred over the weekend and they were
18 seeking information from the police; is that right?

19 A. That's correct, yes.

20 Q. Again, it is your understanding, is it, that nothing had
21 appeared to have been communicated ahead of your call on
22 the morning?

23 A. Nothing at all, Social Services did not know where mum
24 was.

25 Q. Is it right that you understand from the records that the

1 ward manager confirmed that safeguarding remains open,
2 and he confirms that he contacted the safeguarding team
3 for advice on closing the safeguarding; is that right?

4 A. That's correct, yes.

5 Q. And he records to Social Services that the safeguarding
6 team wish to know your mother's whereabouts, the measures
7 in place to protect her, as well as the measures in place
8 to protect your father at home.

9 A. That's correct.

10 Q. Is it right that from your reading of the records, it
11 appears that the ward manager had no answers to these
12 questions and that he contacted your mother's care
13 co-ordinator to find out those answers?

14 A. That's correct.

15 Q. In response to Social Services, from what you have seen,
16 you understand the ward manager has recorded that your
17 mother's care co-ordinator was unable to, you quote this
18 in your statement, provide robust information?

19 A. That's correct, yes.

20 Q. And as a consequence, you understand that a meeting was
21 arranged to discuss this for the 16 March, so the
22 following day.

23 A. Yes, as far as I can recall from the records, yes.

24 Q. In the meantime, is it your understanding, and this may
25 be based on a discussion that your husband had with your

1 mother's care co-ordinator, that your mother's care
2 co-ordinator did not know where your mother was staying
3 until the 16th?

4 A. That's correct, yes.

5 Q. So in spite of the fact that you had called Social
6 Services on 13 March, whilst the incident with police was
7 unfolding, and called them first thing on the Monday
8 morning, and they had notified the ward manager and
9 matron of a serious incident, as far as you understand
10 it, the care co-ordinator wasn't aware of your mother's
11 whereabouts at that time?

12 A. Exactly, yes.

13 Q. I want to move on to the concerns that you articulate
14 about the communication between Ruby Ward and your
15 family. Towards the end of your statement you describe
16 yourself as "the family spokesperson".

17 A. That's correct, yes.

18 Q. Would it be right to say that you also adopted this role
19 throughout the period that we have focused on, before
20 your mother's death, the January to March period?

21 A. No, my sister was involved in some of the correspondence.
22 But then she became unwell. She has been [unwell]
23 following what happened here, so she was too unwell.

24 Q. So would it be fair to say that effectively it was joint
25 responsibility whilst your mother was still alive and

1 then afterwards you took on the role of a spokesperson?

2 A. Yes.

3 Q. And to the extent there was contact between mental health
4 services and other members of your mother's family, was
5 it such that the information was being passed between
6 you. So you were aware of what your sister was doing and
7 vice versa?

8 A. Exactly, yes.

9 Q. You have explained in detail the extent to which
10 information about your mother was communicated to you in
11 the 9 February video call meeting. At any stage were you
12 told that your mother had not given consent for
13 information about her care or treatment to be shared with
14 you?

15 A. No we weren't told that she hadn't given consent, no.

16 Q. I want to turn, briefly, to the language used in the
17 medical records, with regard to the relationship between
18 your mother and other family members. You explain, in
19 your statement, the breakdown in the relationship was due
20 to your family's real fears of your mother's violence and
21 aggression and that you communicated this to Dr B.

22 A. Exactly, yes.

23 Q. And you referred to and expressed shock about seeing
24 notes stating that there was no need for care of any sort
25 or Social Services input and describing the situation as

1 a family feud. Is that right?

2 A. That's exactly what happened, yes.

3 Q. Are you able to say how those written notes and that
4 description matches up with the impression you were given
5 by ward staff, at the time, when you discussed the
6 difficult relationship your family had with your mother
7 at that time.

8 A. I don't think that they -- I don't know what they thought
9 really. I'm sure they didn't believe anything we said.
10 It clearly wasn't important enough to put down in writing
11 on the records at all. I think they just disregarded
12 everything we said.

13 Q. You explain that after your phone call with Dr B on 22
14 January, where he told you that he would not treat your
15 mother and she would go home without support, your family
16 felt you had no option but to complain and seek advice
17 and so your sister approached PALS for advice verbally;
18 is that right?

19 A. That's correct, yes.

20 Q. And you have since seen a record from 27 January
21 recording advice from WR (ward round) was that:

22 "Nursing staff are not to contact family until
23 advised otherwise", and noting that your family had
24 contacted PALS.

25 Is that right?

1 A. That's correct, yes.

2 Q. Is it right that it was your view that your family's
3 contact with PALS seems to have pushed the ward to refuse
4 to speak to you?

5 A. That's correct, yes.

6 Q. And are you able to recall whether there was a change in
7 tone or a decline in the amount of contact from the ward
8 staff at this time?

9 A. We didn't have much contact with them anyway they were
10 have very, very difficult to get hold of on the phone.
11 We tried to call numerous times to find out how mum was
12 doing but it was almost impossible. I mean sometimes,
13 when it was really, really important, I had to leave
14 messages on Dr B's secretary's answering machine, just so
15 that I could get some information or give them
16 information. It was very poor communication.

17 Q. And you comment in your statement that during the patient
18 safety incident investigation ward staff accused your
19 family of not contacting the ward, which you say is
20 factually incorrect.

21 A. Yes.

22 Q. And is it right that you say that far more calls were
23 made by your family --

24 A. Yes.

25 Q. -- than are recorded in the medical records?

1 A. That's right. Obviously, I have to accept that a lot of
2 the calls didn't get through because we just tried all
3 day and sometimes into the evening and it was virtually
4 impossible and it just rung and rung and rung, the phone,
5 you couldn't get anybody to answer the phone on the ward.

6 Q. Are you able to say roughly how regularly you and other
7 family members were contacting the ward at that time?

8 A. Initially obviously, very, very regularly, but obviously
9 we got to the point where we are just could not get
10 through to them, so it seemed a futile exercise.

11 Q. In terms of efforts made by the ward to rebuild the
12 relationship between your mother and your family, on 27
13 January the ward, is it right, did invite you and your
14 sister to a video call with your mother?

15 A. They did, yes.

16 Q. And you were also told, is this right, that your father
17 was excluded as Ruby Ward felt that this would be
18 triggering for your mother?

19 A. That's correct, yes.

20 Q. At the same time, was it your understanding that the
21 intention, at that time, was for your mother to return
22 home to live with your father from the ward perspective?

23 A. I believe so, yes.

24 Q. Is it right that the PSI investigation report concluded
25 that mental health family group conferencing was

1 something that should have been considered to rebuild
2 your mother's relationships with her family before
3 discharge?

4 A. That's correct, yes.

5 Q. And as you understand it, this was something that
6 certainly wasn't communicated to you and as you
7 understand it was not explored.

8 A. Not at all.

9 Q. You explain in your statement that no discussion was ever
10 offered by the ward staff to see how, as a family, you
11 might be able to help your mother?

12 A. That's correct, yes.

13 Q. What, if anything, do you feel was done in order to
14 provide information or suggestions about how you as a
15 family might support your mother?

16 A. I don't think there was anything. I can't say there was
17 anything that I can think of.

18 Q. Is there anything further you would wish to say in
19 relation to the engagement and communication that the
20 ward had with your family?

21 A. It was appalling and virtually non-existent.

22 Q. Thank you. I want to now turn to your concerns regarding
23 the treatment of you and your family and the quality of
24 the investigations following your mother's death. On 16
25 March your husband returned to your parents' address to

1 meet police and collect clothing for your father
2 following his arrest on 13 March; is that right?

3 A. That's correct, yes.

4 Q. And when the officer who attended could not get a reply
5 at the door, is it your understanding that he called for
6 backup and other officers forced the door finding your
7 mother dead in the locked bathroom?

8 A. That's correct, yes.

9 Q. You understand that your husband was then questioned and
10 held at the scene for a couple of hours whilst the police
11 eliminated him as a suspect?

12 A. That's correct, yes.

13 Q. Is it right that that evening, when the police returned
14 the keys to you, you were told they had done their best
15 to clean up the bathroom?

16 A. That's correct, yes.

17 Q. However your husband later told you that when he, your
18 son and brother-in-law went to clean it, they found the
19 bathroom in complete disarray and you described wet
20 bloodstained towels strewn across the floor and several
21 sharp bloodstained knives and blood stains splattered
22 around the bathroom; is that right?

23 A. That's correct, yes.

24 Q. Your son later told you how shocking it had been for him,
25 and how surprised he was that family were expected to

1 clear and clean up this type of death; is that right?

2 A. He was, yes.

3 Q. You suggest towards the conclusion of your statement,
4 that families should be offered support following this
5 type of death and that the Inquiry should investigate
6 this. Is that right?

7 A. Yes, I believe so. I don't think the family should be
8 expected to have to do that.

9 Q. Thank you. You understand that there was a post-mortem
10 examination following your mother's death, which
11 concluded that the cause of your mother's death was old
12 age, and it is right to say that there was no inquest in
13 your mother's case?

14 A. That is correct, yes.

15 Q. I want to turn now to the formal complaints about your
16 mother's care and treatment.

17 A. Yes.

18 Q. It is right, is it, that these began a month before her
19 death when your sister submitted an official complaint to
20 PALS via e-mail?

21 A. That's correct, yes.

22 Q. And after receiving the documentation from your mother's
23 GP, including Dr A's report and diagnosis of bipolar?

24 A. That's correct, yes.

25 Q. Is it right that this complaint was never effectively

1 actioned, as you were told that your mother's permission
2 was required to proceed with the complaint?

3 A. That's correct, yes.

4 Q. And it is your understanding, is it, that PALS sent a
5 letter to your mother, at her temporary accommodation, on
6 11 March, nearly a month later, but she never signed it?

7 A. No, it was in her effects when she passed, but it hadn't
8 been signed, no.

9 Q. And that was the letter seeking the permission to allow,
10 effectively, you to lodge the complaint on her behalf?

11 A. Exactly, yes.

12 Q. Thereafter, after your mother's death, this complaint was
13 then converted into first patient safety incident
14 investigation, five days after your mother's death; is
15 that right?

16 A. That's correct, yes.

17 Q. And you identified that the PALS system has no mechanism
18 to action complaints made by anyone other than the
19 patient, without the patient's consent, and recommend
20 that this should change; is that right?

21 A. Exactly, yes.

22 Q. And you say in your statement that often a patient is not
23 in a position to raise a concern due to their illness,
24 whether physical or mental, and family members, carers
25 and friends must be able to raise the alarm and make a

1 complaint on their behalf.

2 A. I think so, yes.

3 Q. You refer in your statement then to a patient safety
4 incident investigation about which you have a number of
5 concerns; is that right?

6 A. That's correct, yes.

7 Q. Firstly, is it right that you consider that the fact that
8 the member of the patient safety investigation team
9 providing the safeguarding input was a member of the team
10 who had been responsible for your mother's safeguarding
11 investigation; is that right?

12 A. Yes it was, yes.

13 Q. And it is your view, in your statement, that this
14 severely compromised the investigation?

15 A. I'm quite sure, yes.

16 Q. Secondly, you describe the PSI making unfounded
17 accusations about your family, without any corroborative
18 evidence. Are you able to provide any further details as
19 to the type or tenor of the allegations that you say were
20 made in the report?

21 A. The actually refers, obviously, to the fact that they
22 seemed to believe there was some family feud going on.

23 THE CHAIR: Do you know what might have been the genesis of
24 that? Did you ever find out?

25 A. No, I never did, no.

1 THE CHAIR: Thank you.

2 MS LLOYD-OWEN: Thirdly, you outline failures in involving
3 your family in the PSI investigation process and in
4 particular the need to -- you refer to in your statement
5 the need to repeatedly chase responses from the family
6 liaison officer, receiving the PSI investigation report
7 six weeks after its completion, and not being given the
8 opportunity to view and provide input on the draft report
9 despite the clear guidance.

10 A. That's correct, yes.

11 Q. Is it right that no explanation has ever been given to
12 you for this six-week delay in providing the report, and
13 the failure to share the draft with you?

14 A. No explanation has ever been given.

15 Q. At paragraphs 287-289 of your statement you outline your
16 efforts to chase a meeting that the family liaison
17 officer had suggested to discuss your family's concerns
18 arising from seeing your mother's medical records.

19 A. Yes.

20 Q. Is it right that you received the medical records and
21 then wanted to provide further input in terms of the
22 concerns that you had?

23 A. That's right because at that point we had no idea that
24 the report had been signed off.

25 Q. When you were able to secure a meeting, is it right that

1 the EPUT complaints department had informed you that such
2 a meeting could not include discussion of your further
3 concerns, and would be limited to the PSI investigation
4 report itself?

5 A. That's correct, yes.

6 Q. Thereafter, the chief executive of EPUT complaints
7 department, is it right, e-mailed stating that EPUT
8 considered all matters raised to be addressed in the PSI
9 investigation report and suggested that if you
10 dissatisfied, you should approach the Parliamentary and
11 Health Service Ombudsman?

12 A. That's correct, yes.

13 Q. You then set out in detail at paragraphs 287-302 the
14 steps you took thereafter to seek to get answers,
15 including supplying a list of further issues to EPUT
16 complaints department and completing the Parliamentary
17 and Health Service Ombudsman complaints form?

18 A. That's correct, yes.

19 Q. And is it right that when you completed that form you
20 were told that EPUT had to respond to your further
21 questions before the Ombudsman could intervene?

22 A. That's correct, yes.

23 Q. You also outline a meeting that you had thereafter as
24 part of what you understood to be a legal style
25 investigation in relation to your further complaints at

1 EPUT?

2 A. That's correct, yes.

3 Q. And on receipt of the report from that further
4 investigation, you describe your frustration at yet
5 another failure by EPUT to provide meaningful answers; is
6 that right?

7 A. That's correct, yes.

8 Q. Is it right that thereafter, although you could have
9 pursued the matter with the Parliamentary and Health
10 Ombudsman, you and your family felt emotionally
11 exhausted?

12 A. Exactly, yes.

13 Q. And you refer to that emotional exhaustion in your
14 statement, and as the family spokesperson at that point,
15 is it right you felt you could not continue in that role?

16 A. No, that's right. We had another family bereavement and
17 it just wasn't possible. We didn't have the strength
18 anymore to pursue it.

19 Q. You also mentioned contacting Healthwatch but not taking
20 it any further because they were, as you understood, only
21 able to offer advocacy.

22 A. That's correct.

23 Q. Are you able to say at what stage that was in the
24 chronology of when you contacted them?

25 A. I don't know. I would have to look, but I can't remember

1 exactly what stage that was that we actually approached
2 Healthwatch.

3 Q. You also refer to approaching the CQC by a telephone call
4 and registering a complaint but then receiving no
5 feedback or information following this complaint; is that
6 right?

7 A. I think that that was after the PALS. My sister started
8 the PALS complaint. I contacted the CQC.

9 Q. So that was earlier in the process, was it?

10 A. It was yes, much earlier.

11 Q. So would that have been whilst your mother was still
12 alive?

13 A. Very possibly, yes.

14 Q. And that was a call made by your sister?

15 A. No, I made the call to the CQC, yes.

16 Q. Is there anything further you would wish to say about the
17 accessibility of the complaints processes as you
18 experienced them?

19 A. Just a complete and utter whitewash, it didn't get to the
20 bottom of anything really and it was just such a
21 frustrating process. I still don't know why these things
22 happened and my mum died. I still don't understand why
23 those things happened, so clearly it didn't work, and
24 doesn't work.

25 Q. Thank you. I now want to go through the recommendations

1 set out in your witness statement, and I will ask if you
2 would like to say anything further about them or how they
3 could have impacted on your mother's case and treatment.
4 It may be that you feel we have covered them sufficiently
5 already, but I would like to make sure you have had an
6 opportunity to say everything you would like to say in
7 respect of your recommendations. We have already
8 discussed your recommendation that the PALS system
9 introduce a mechanism to enable complaints to be made on
10 behalf of a patient without their consent, and your
11 recommendation that families should be offered support
12 following the kind of bereavement you experienced.

13 A. Yes.

14 Q. You outline further recommendations at pages 60-61 of
15 your statement, largely from paragraph 349 onwards.
16 Please can we have page 60 on the screen, Amanda. So you
17 see there at paragraph 349 you express the view that
18 getting to the truth is seriously hampered by the fact
19 that services investigate themselves and you propose in
20 the next paragraph that investigations must be
21 independent and strictly regulated; is that right?

22 A. Yes, that is correct, yes.

23 Q. Is there anything further you would like to say about
24 that?

25 A. Yes. I think investigating themselves gave EPUT the

1 ability to basically cover things up. I think if it was
2 done more independently, there may be an opportunity for
3 the truth and understanding for the families, yes. They
4 cover up. They close ranks. I have no answers and I
5 don't know if I ever will. I am hoping here will
6 hopefully give me some answers.

7 Q. Yes, and at paragraph 353 at the bottom of the page, you
8 describe the emphasis as wrongly placed on investigating
9 systems and learning, rather than individual culpability.
10 Is that right?

11 A. Yes. I think there has to be accountability and those
12 that made the decisions ultimately led to someone's
13 death, they need to be accountable. No two ways no,
14 "ifs", "buts", no "maybes". It happens time and time
15 again because all we are doing is investigating the
16 system and not investigating the people that are making
17 the poor decisions.

18 Q. And you say at the same paragraph that your experience is
19 that learning is often never implemented or there are
20 huge delays.

21 A. I know that for a fact because the meeting we had in the
22 December with the PSI team, when I quizzed them on had
23 Ruby Ward had the learning carried out, they told me that
24 that hadn't happened and that was -- Mum died in the
25 March and this was the December, and the learning, as far

1 as I could glean from them, had not happened. And they
2 couldn't actually give me a date when it was going to
3 happen.

4 Q. And if we can turn to page 61, at paragraph 355, you
5 express the view that where the death of a patient or
6 serious injury is suspected, individual staff members
7 should be prevented from continuing to work with
8 vulnerable individuals until the investigation is
9 complete?

10 A. I think that's the only way to safeguard people because I
11 don't know, unless there's some accountability, it's just
12 going to keep on happening time and time again.

13 Q. There is then a heading "Recommendations for Change"
14 under which you express your family's view that with
15 proper assessment, diagnosis, treatment and support for
16 your mother and family, you could all have been looking
17 at very different outcome for your mother and father?

18 A. I believe that categorically, if mum had been treated,
19 things would have been different. My dad wouldn't have
20 been pushed down a legal route that he never should have
21 had to have gone down. My mum was totally unable to do
22 anything legal herself because she was in such turmoil,
23 you know. To be actually pushed down that route, that
24 the only way you can stay safe is for you to take legal
25 action, but still mum was unwell and needed help, she

1 (4.20 pm)

2 (Adjourned till 10 o'clock tomorrow morning)

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