Witness Name: Joanne Woolley

Statement No: 1

Exhibits: N/A

Dated:

THE LAMPARD INQUIRY

Witness Statement of Joanne Woolley

I, Joanne Woolley, will say as follows.

Preliminaries

1. My name is Joanne Woolley.

2. I am the daughter of Norman Noah Dunkley. My father was born on 8 October 1931 and died on 15 March 2022 at Wensley House care home.

3. In November 2024, I gave a commemorative statement to the Inquiry about my dad's life and the impact of his death on our family. I now make this statement to the Inquiry to address the matters that I raised during this meeting as well as additional matters I have since been asked about.

Norman's Mental Health History and Diagnosis

4. My father never had mental health issues before 2021. My mum had died of lung cancer some years before in October 2010 and I had cared for her at home with my dad. This might have been the start of his mental health struggles. He could not cope without my mum. I used to go to see him at the farm every day, I took over the running of everything. My dad was old school, he never showed any emotions, but I think he really struggled with my mother's death.

5. By summer 2021, I was with my dad every day as his main carer and my sister would look after him at weekends. He started telling us that he was seeing people in the fields. To begin with, we thought that it was possible because it was a rural area, and people would walk around at night. This carried on for a few weeks until my nephew suggested we get some cameras put up. Then one night my dad called us to say that there were people up there; we looked at the camera and explained that there was no one there. He got very shirty. This was at the weekend, and it was the first time that my sister and I thought there was something more going on.

6. On the following Tuesday, we spoke to our father to suggest that we go to the doctor because he was seeing things that were not there. I called the GP who took it very seriously; he said Norman needed to come in for some blood tests. The GP said they would send an on-call doctor out. That doctor came to see my dad, we explained what was happening and he said it sounded like 'sundown dementia' when you get hallucinations in the evening.

7. At the same time, he was having bad upset stomachs. We sent in a stool sample and the doctor got back to us quite quickly to say the results were not good, they indicated that he likely had bowel cancer. The doctor asked what we want to do about it. Dad did not want to go through the treatment and going in and out of hospital, he wanted to stay at home. The doctor agreed and told us we could keep him at home and medicate him and just make him comfortable. We had a good relationship with his GP.

8. We did not know until later that my dad had been telling the nurses who came to deal with his catheter that he had seen people during the night. He

knew he was ill, but he did not know how ill he was. I think he knew that if he told us what he was seeing, we would do something about it.

9. The hallucinations started in summer and continued until his birthday on 8 October 2021 when he turned 90. It escalated after that. A week later, around 15 October, on a Wednesday morning, my dad called me and said, "they're in here and they're trying to kill me". I went up to the farm with my husband right away. My dad had locked himself in, it looked like he was having a stroke, his eyes were black. I tried to calm him down and persuaded him to open a window so I could climb in. He had been up all-night fighting imaginary people, he said the farm had blown up, it was horrific.

10. We called an ambulance. By the time they arrived, he had settled down, but the paramedics came in and said he should go to hospital. My dad went into Whipps Cross on a Wednesday, he was assessed on Thursday and by Saturday he was at St Margaret's as an inpatient. He spent the next five months there. He was transferred to Wensley House on 7 March 2022. This was where he died only eight days later.

11. It was when he was at Whipps Cross that the doctor there told us he likely had Lewy Body Dementia ("LBD"). That was when LBD was first mentioned although my dad never had a scan for it – from our own research we found out that the scan is quite expensive. At St Margaret's they raised a diagnosis of vascular dementia and did not consider LBD at all.

Assessments

12. On the Wednesday I was at Whipps Cross Hospital with my dad for 15 hours. They told me there was nothing wrong and that he needed to go home; I insisted that they admit him. I said I can't cope, and he cannot cope at home. The two doctors looked at me as if to say he was being kept in just to shut me up, and they admitted him that night.

13. On Thursday morning, I got a call from the mental health doctor at Whipps Cross who said my dad was more ill than they thought and he needed to go

for a mental health assessment in St Margaret's. This is when they said he likely had LBD.

14. I went to St Margaret's soon after he got there. I wanted to know how he was, so I was there every day. I travelled over four hours to get to the hospital to tell them how he had got there and what had before, but they were not interested. They thought their own assessment was all they needed.

15. My dad had never had a mental health assessment before, as he never had any mental health issues. His first assessment was at Whipps Cross. I assume it was what he was saying and the way he was presenting that got the doctor to do the assessment. I do not know what the assessment involved. Looking back, it makes me realise how little we were told; no one told us if it was a specific assessment, or routine, or anything about it. I was his main carer and next of kin and no one sought any information from me about his symptoms or the lead up to his admission.

16. About three weeks into his stay at St Margaret's, I believe it was **[I/S]** the occupational therapist, called me to tell me her role. She said she had spoken to my dad and asked me what I thought about him going into a home. She said there was going to be an assessment to see what his needs were. I could have told them his needs, but they did not ask for my view, they just wanted to do it on their own.

17. I was never told what the follow up steps would be. Suddenly, they had assessed him. One Monday, **a doctor** called me and said that my dad had vascular dementia and needed to go into a care home. I raised the LBD diagnosis, but he did not listen, he just insisted it was vascular.

18. At the time I felt Whipps Cross had done things right, but now I do not. My dad was not there very long, but in that time, they did not listen to or speak to us and I do not think he was assessed properly. The assessment at St Margaret's was inadequate; they did not listen or communicate with us. They diagnosed vascular dementia from a scan and did not listen when I raised the LBD, this is despite him having all the symptoms of it.

19. The social worker at St Margaret's and the doctor conducted an assessment around December 2021 after which they concluded that my dad should be in a care home. The social worker, [I/S] did her assessment after Christmas. My sister, my friend Paul, and I then had a meeting with her to discuss my dad's needs. He was not moved to the care home until 7 March 2022.

Admissions

20. My dad was never admitted to mental health inpatient services before this. He never went home once he was admitted to Whipps Cross in October.

21. I do not know if the admission was under section, it was the doctor at Whipps Cross who made the decision to admit him. The reasons for the decision were not communicated to us.

22. We should have had more to do with the way he was admitted and should have been told exactly why he had to be admitted. If I had realised what was happening, I could have spoken to my dad's GP. I would have tried to manage him at home, but this option was never considered.

23. After about three weeks at St Margaret's the Occupational Therapist called to say my dad had been settling in well, but I did not believe her; my dad was not happy in that environment. The one thing I tried to avoid was having my dad admitted to any hospital, I had basically given up work so I could keep him at home where he wanted to be. If they listened to me, he would never have been admitted; he would have been at home like he wanted.

Ward Environment

24. Before Christmas 2021, we were seeing my dad three times a week at the ward. We never stopped visiting and we could see him as much as we wanted. It was only during Covid that we would have to book our visits, but they were not stopped.

25. Whenever we would see him, it was in a secure centre. We were buzzed into a room, and we would see him there. The room itself was unpleasant.

26. We never saw any of the ward environment, not his bedroom or anything like that. We were never given that option. From my understanding, they would just get my father up, dress him, sit him in a chair and leave him there. He never went outside, and we were never given a courtyard or anything to wander around in. He was quiet and did not want to be there. We were told that there was a singalong, but we knew our dad would not have done that. The staff told us that things were happening on the ward, but I do not think what they were saying was right.

27. When we would go and see him, he was hardly communicating. It was horrible for us to see. He hated it right from the beginning and I felt like he just wanted to disappear and go home.

28. There were several occasions where I felt like the staff did not know who my dad was. They could not tell me his needs and on multiple occasions I felt that the information they were giving me was wrong. We never challenged what they reported because we were trying to get our head round this unfamiliar experience.

29. We did not feel like his basic needs were being met, such as hygiene and nutrition and there was no privacy or dignity afforded to patients. My dad was quite a big man. It was not until he got to Wensley House that we noticed he was like a skeleton. He had lost so much weight. My dad's eating had started to deteriorate while he was at home. While in St Margaret's, they said he had a good appetite but when he got to the care home, his false teeth did not fit from where he had lost all the weight. Once again, we felt like we could not trust the information provided by the staff.

Staffing Arrangements, Training and Support

30. I do not feel that the care offered to my dad was adequate. The staff did not listen to anyone, nor did they respond to his needs. They never told us how he was; it was only if we asked how he was that they would say he is fine, but this was very different to what we observed when we saw him.

31. There was one member of staff, an older gentleman, who would help and would trim my dad's beard but then he retired.

32. There was one incident which was really unpleasant for us. One of the side effects of LBD is that the patient says crass things because they are not in their right mind, I did not know about this at the time. One day we went into St Margaret's, and a nurse made a comment about some of the stuff my dad had been saying to her. She was half laughing but I was absolutely devastated. I do not feel that the staff thought seriously about what they were telling us. They were insensitive and did not consider how upsetting something like this incident would be.

33. There was then an incident when my cousin went to see my dad. While she was there, somebody from the social work asked him to sign a form; my dad said no you need to speak to my daughter. My aunty called to say this had happened and that he had been asked to sign a form about finances (this was assumed, I was never told what it was). I rang the ward immediately and asked what they were doing. I had made clear that if they need anything they should contact me and go through me.

34. We raised this issue at a meeting before Christmas 2021. The doctor accepted that this should not have happened, but they did not explain why it happened or what he had been asked to do. We do not know who the staff member was, just that it was to do with a social worker under [I/S] named [I/S]

35. It did not seem like the staff had training on how to give difficult news to family members. The decision that my father had to move to a care home was communicated in a matter-of-fact way, the staff did not recognise the significance of what they were saying.

Care Management and Plans

36. When we went up to see my dad after Christmas, there were conversations with [I/S], the social worker, about his needs. There was no mention of any care plan, and we still have not seen one. We were never aware that there was one; if there was, we were never approached, and our views were not considered.

37. The social worker said she had spoken to my dad, and he was quite switched on and could manage himself well, but this was at odds which what we knew of him. I do not know if she ever asked him where he wanted to be, but we know if she did, he would have said at home with us.

38. They told me that they were going to tell him he was going into a care home which I objected to. I said we are going to tell him. They never talked about asking what my dad wanted, only telling him what was happening.

39. I was involved at the planning meeting in December 2021, where I felt like I was railroaded. Overall, we were never asked our opinion, and when I shared my views about palliative care in the meeting, I was told I was mad.

40. In the December meeting, they were leaning towards nursing but when we had a meeting in the new year, it was just care according to the social worker's care plan. I did not realise that nursing homes in fact do both types of care, no one explained the difference.

Treatment

41. At the time of the LBD diagnosis, there was no treatment discussed. I raised this diagnosis when my dad moved to St Margaret's, but they did not want to know. After he had been there for some time, they made their own diagnosis of vascular dementia from a scan, as I understand it. Again, there was no particular treatment or management discussed with us.

42. While he was at home, I would have to put my dad in pull ups because of his issues with his bowels. When he went into St Margaret's, I gave them the pull ups, but they refused to use them. It really upset him. They said he did

not need them even though my dad and I explained that he did, and that he had them at home. The nurses threw them on the bed despite knowing my dad could not put them on by himself. He asked for help and the nurse said no. We persisted and eventually the nurses started using them.

43. The doctors called me before the group meeting in December to say that my dad had vascular dementia. I do not know how long before this call they had taken him for a scan. They gave me some leaflets on what to expect but that was it. They still had the view that my dad was physically fit, despite him now using the pull ups.

44. My dad also had a permanent catheter. He used to have it on a stand at home but because he was mixing with other patients on the ward, they wanted him to have it strapped to his leg. On one occasion, my sister and I went to visit him, and his leg was all ulcerated. The ward staff had not noticed, my sister had to point it out to them. My dad was clearly not with it and the staff had just ignored him. Once my sister pointed it out, they then treated his leg.

45. After the meeting with the doctors, nurse and care assistant, in December 2021, my dad had a patch on his arm. It looked like a nicotine patch and that is what my dad thought it was. I assumed it was administering some kind of medication to treat his hallucinations, but I was never told what it was. His symptoms did not change, however, he was still presenting as before.

46. We were never told what medication he was on, if any. I felt he was being sedated on the ward, but we do not know of any treatment given. The only medication I am sure he was getting, was sleeping tablets.

47. While he was in St Margaret's he developed a very bad urine infection. The ward rung me to tell me. Before he was admitted, I would have my dad on permanent antibiotics because of how often he got infections with his catheter. I would know what to look out for and give him the antibiotics. I think they took this medication off him on the ward.

48. On separate occasions, around Christmas 2021 and early 2022, a doctor from St Margaret's called me to say my dad had been taken to Princess Alexander Hospital because he was unwell. They said they would let me know when he was back on the ward. I assumed this was to do with the catheter being blocked but I was never given any details. I was never able to look around the ward to assess whether they could handle my father's needs or the changing of his catheter. I thought the secrecy could have been down to my dad being more ill than they thought, and them not wanting to tell me.

49. At the care home, my dad started to take medication but shortly after that, he could no longer swallow so they could not administer it.

Safety

50. As far as I know, my dad was not subject to any physical or sexual abuse.

51. I know that he did not feel safe on the ward because he was not with me. The incident with the adult pull ups would have made him feel unsafe too. He seemed frightened and had a haunted look about him whilst he was on the ward. I felt he would have been safer at home.

52. When he first went in, they were doing observations, I know this because that is why they first thought he needed care not nursing. I remember they said they were doing observations every 15 minutes because of his hallucinations at night, although when my sister and I visited him, he was also hallucinating during the day. I do not know when these observations stopped.

53. If the staff had observed him properly, they would not have thought he was physically fit. At home, I would have him in Velcro shirts because he had arthritis and could not dress himself. He could not do anything for himself.

54. I was never consulted about any decisions around observations.

55. As far as I know, my dad was never physically restrained. The staff had told me his hallucinations were bad at night, and he would lie in bed and wave his stick around. They never said what they did to stop it or to help him. He

was allowed to keep his walking stick but by then he was having trouble walking so used a walker instead.

56. We often tried to get information on how he was, but we never got much feedback. The whole thing was so upsetting, to see him in such a state.

Leave, Absconsion and AWOL Patients

57. My dad was in no fit state to make requests for leave as he still believed his house had been blown up. He got in his mind that we were going to take him out of the ward, but he would not have been physically able to do that; we tried to remind him that we only saw him on the ward.

58. We did not make any requests for leave mainly due to his physical limitations.

Transfer

59. Besides the short trips to Princess Alexander Hospital, my dad was never transferred out of the ward until he was moved to Wensley House.

Discharge

60. My dad was discharged to Wensley House on 7 March 2022. There was no discharge plan, and the Trust did not say anything about medication or how he would be treated. My only involvement was choosing the care home.

61. As soon as I found the care home, we started getting it ready for him. We found it on a Wednesday and by the following Monday, the Trust had moved him there. There was no real preparation for the move on the Trust's behalf. Thankfully we were able to tell him before the Wednesday, that he would be going to a care home. I don't think he was aware what was happening to him at this point, he just thought we were taking him home.

62. When he got to Wensley House, his legs and feet were swollen, and his toenails had not been cut. It seemed like nothing had been done at St Margaret's. He was transferred with a blocked catheter. The pain he must have been in must have been excruciating. The whole experience must have been horrendous. He seemed to give up.

63. My main concern about the discharge process was that there were no notes from St Margaret's. When I had found the care home, [I/S] the Chief Nurse there, rang St Margaret's to get my father's medical history. The Trust would not release his notes; the Chief Nurse said she had never encountered a hospital that would not release patient notes, and the owner, [I/S] said the same thing. Luckily, they saw the situation my dad was in and accepted him, but they were never given any record of what had happened in the ward. Still now, we have not seen any notes from the Trust.

64. I had to tell the care home what his needs were, they had to start from scratch. As soon as they saw him in the home, he looked awful. He had only been there a few days, when I got a call from the Chief Nurse saying he could not eat.

Engagement

65. We had meetings with St Margaret's in December 2021 and January 2022.

66. Just before Christmas 2021, a doctor called and told us my dad had vascular dementia and that he needed to go to a care home. Paul, our family friend, said we need to have a meeting with them which we did. The doctor [I/S] the senior nurse, and a care assistant were there. They were supposed to be telling us how my dad was doing but they could not tell us much about him. They said they had assessed his needs but again they could not tell us much about what they were. We said we were concerned he was not receiving the correct care as he was becoming very insular. I asked about palliative care but was dismissed.

67. The doctor raised the vascular dementia diagnosis. When I raised the LBD diagnosis, I was dismissed. I raised his hallucinations and that we would often go to visit him in the evening, and he would be having violent

hallucinations. The doctors whispered to each other and after that my dad was always wearing a patch on his arm which I assumed to be treatment.

68. At this meeting we were given a social worker, [I/S] although we did not understand what for. They said I would not have coped at home, so my dad had to go into a care home, and they wanted to discuss the finances. They were saying he needed nursing care, then the next minute they said he needed just a care home; I thought they were separate things. I tried to say to the doctor that he needed palliative care at home, but they disagreed.

69. Before he was admitted, the GP had said my dad was at the stage where he needed to be kept comfortable. The GP had said there was more going on and he was erring towards palliative care because my dad's stool sample had showed blood in his bowel. I explained all of this at the meeting. As far as I am aware, the ward staff never spoke to the GP or tried to find out any information relating to my dad's physical or mental health issues.

70. At the meeting, the doctor implied that I needed help because of what I was saying. That was the extent of their dismissal of my view. I have never experienced doctors like this before. If they had listened, my dad would have come home for palliative care, that is what he needed.

71. After the meeting, **we had further calls with the social worker** and a call with **the senior nurse.**

72. The meeting in January 2022 was a planning meeting. This is when the issue of the signing of the document came up as detailed earlier in this statement. **The social worker** then gave us some information about care homes – what we could expect, the costs, and a list of possible options.

73. We came out of both meetings feeling confused and that we had not been listened to. Our overwhelming impression was that the Trust just wanted to get my dad into a home.

74. We then went to a few and eventually decided on Wensley House in Epping. We felt that St Margaret's did not want my dad there anymore [I/S] the nurse, called us one evening and just said "have you found one yet?". **The social worker**

then called too and asked if we had found anywhere. I explained that it took us time to find somewhere and get our heads round self-funding or council-funded, but we had decided to self-fund. She replied, "oh if I had known that I would have backed out a long time ago". I never saw her again nor did I hear from her once she found out we were dealing with our own finances separately. We could not believe that she withdrew like this and told us she would have backed out long ago. She had never said her involvement would change depending on the type of care home which added to our confusion. There was no involvement from her or the nurse after that, even though the nurse should have come and visited to make sure everything was ok. I was left feeling like the social worker was just in it for financial gain as she worked for the council social services and the council would have benefited from us choosing a council-funded home, rather than a self-funded home.

75. Generally, the Trust were not interested in what we had to say. When my mother was ill, the doctors always wanted our input, but they never wanted to hear what we had to say in my dad's case. If I had a care plan and proper support, I would have been able to care for my dad at home. I chose the care home, but I was not involved in any decision about whether he should be going to one at all. I wanted him home so I could provide palliative care.

76. My dad had no say in the decisions about his care. If anyone had asked, he would have said he wanted to go home.

Concerns and Complaints

77. We were never given any information on how to raise concerns formally. The only time we raised them before my dad died, was at the meetings and on the phone when I called about my dad being asked to sign something.

78. It was not until he died that we questioned what had happened. I was not in the right frame of mind before, I felt something was not right but did not know who to go to or how to complain. We had never been in this situation

before. We were never given any expectation as to what the standards were for any treatment. We were just told he has dementia and off you go.

79. In the meeting when I did complain about the standard of care, I was shut down. There was never any follow up from anyone in the meeting and I was never given the impression that the Trust had considered my input. The doctors denied that my dad needed palliative care and that was it. The same thing happened with the pull ups. I explained why he needed them, that there was a high chance he had bowel cancer but could not cope with the hospital visits if he were to have treatment, and the staff just dismissed it saying there was nothing wrong with his bowels.

80. It did not make sense that they would not listen. This was my father's dignity; I was only trying to ease things for him. There was no acknowledgement when they did take my advice e.g. when they started using the pull ups.

81. With the issue around signing the document, my dad could just about write his name. He told them to speak to me about signing anything. One moment the staff told me he had capacity, the next they said he did not know what he was doing. When I got on the phone to [I/S], the occupational therapist, she was gobsmacked. The senior doctor then said at the meeting that there was a misunderstanding about a form. No one ever told me what it was they asked him to sign, or why, or who had made the request. The overall impression I got was that my concerns were dismissed.

82. Until I thought about it afterwards, I did not question what Whipps Cross did but in reality it all started there. It is only now that I think he must have been sectioned but I still do not know.

After Norman's Death

83. My dad died on Tuesday 15 March 2022, eight days after he went into Wensley House care home.

84. I had been with my dad on Monday the week before, and on Tuesday morning I got a call from the Chief Nurse to say he was not responsive and that he was not eating or drinking. My sister and I went straight up there. My dad was in bed, his stomach had sunk into his chest. I tried wetting a sponge on his mouth, but he would not open it, he was pretty much unresponsive. I said to the Chief Nurse "this is enough, he is palliative care now", she agreed and got the doctor. It felt like, at this very late stage, we were finally listened to.

85. The doctor agreed that he needed palliative care and provided the appropriate medication. My sister and I stayed with him for five days straight, we would not leave him. He was too ill for us to be able to take him home, but we thought if we were there, he would feel like he was at home.

86. The Chief Nurse made the right call by phoning us. It was much better communication than what we had experienced before. I am thankful that we could be there when he died. They listened to what I had to say and supported us. They did not have to take him, but they did because I explained what happened at St Margaret's. It gave us a week with him and all the grandchildren could come and visit; although we were not at home, we could all be together.

87. My dad passed away on 8 March 2022. I told the care home, and we waited until he was taken out, after the doctor had been.

88. The doctor had come out to redo the catheter earlier in the week. I think this is why it was not deemed necessary to have an inquest because they put my dad's death down to late-stage dementia and old age on the death certificate. I am not aware how this conclusion was reached.

89. I was not offered any support at the time of his death, or afterwards, through the Trust or the care home. I take no issue with the care home, but I wanted some answers from the Trust and reasons for their conduct. If someone had reached out, I would have wanted to know why we were not listened to and why they did not consult my dad's GP at any point.

Quality of Investigations by Healthcare Providers

90. There was no investigation undertaken by the Trust itself and no other investigation into my dad's death.

91. I would have liked an investigation into why we were put in this position to begin with. No one ever looked back to question whether the decision to admit my dad to St Margaret's was the right one. The doctor should have done that instead of telling me I was mad when I raised it in the meeting.

Our Views

92. I am afraid I do not have anything positive to say about my dad's treatment at St Margaret's. The only positive was Wensley House; he got the right treatment at the end albeit in the wrong place.

93. At Whipps Cross, I initially felt like they had done the right thing although, in hindsight, I believe my dad was wrongly assessed.

94. My dad would have said his only concerns about his treatment were that he wanted to go home. I tried to tell them this but whenever I went to them, I was dismissed. My dad was a private man, he liked being at home. For him to be in this environment must have been awful, as it was for me. We felt like we had no choice but to keep him there.

95. In December 2021, I wanted the Trust to assess my dad properly, for him to be given a proper diagnosis and to be sent home for palliative care.

Recommendations for Change

96. My main recommendation for change is that the family need to be heard. When my dad was initially taken to Whipps Cross, they should have spoken to my sister and me to get more information. There should have been involvement of me, as his carer, and his local GP.

97. Secondly, my dad was not assessed properly. The assessment came to the wrong conclusion; it was all rushed through and not thought about. In particular, no one considered that a dying man in his 90s had been at his home for 60 years. For him not to die there, was a big thing. The doctors recognised that he was more ill than they first thought but they did not seek the right information and made the wrong decision in admitting him. He had mental health symptoms, but he had never had mental health issues before; his presentation fit with LBD as identified by the first doctor. Mental health was not the right place for him.

98. There was a significant lack of information. We had never been in this situation before and did not know what to do. We did not know what we didn't know. We thought the Trust were doing their best, but now we question who for.

99. Finally, there needs to be better clarity about diagnosis. In my father's case, there was confusion over whether he had LBD or vascular dementia and, for some reason, no one wanted to make a proper diagnosis. I believe the facts stated in this witness statement are true.

I believe facts stated in this statement are true.

Signed [I/S]

Date: 15/8/2025