WITNESS STATEMENT OF JANE STANFORD PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **Ms Jane Stanford** [I/S] [I/S] am the daughter of Mrs Dorothy Reditt (born on 08 March 1936; died on 16 March 2021.)

2. I am making this statement from a combination of own my own memory of events, knowledge, belief and having access based on my memory of events, from having seen my late mother's records / other disclosure and the evidence placed before the inquest (into my mother's death).

Diagnosis

The development and circumstances of my mother's mental ill-health

An account from my aunt regarding the development and circumstances of mum's mental health

3. Mum's sister was the first person to talk to me about mum's mental health, based on her own experiences and incidents that caused her alarm and concern. My aunt was not a mental health professional, but she was a medical professional, having worked as a nurse, midwife, and health visitor for many years until her retirement. Her training would have given her some knowledge and understanding of mental health issues.

4. Mum's relationship with her sister was the only family relationship that remained intact until my aunt's death. Although it had its ups and downs, there were no major fallings out. Mum's sister seemed to instinctively understand that mum struggled. She was not afraid to confront her, especially when it came to mine and my sister's care. She was very supportive and would often look after us to give mum a break. My aunt told me she had tried on occasion, to persuade mum to seek help for her mental health issues, but without success.

5. My aunt described mum's teenage years as difficult. Mum would often rage at her parents and siblings, and there were frequent confrontations between her and both her

mother and father. Mum was punished harshly by her father, particularly for what he saw as her persistent lying.

6. At one point, while Mum and my aunt were teenagers, mum became so enraged that she held a pair of scissors to her sister's throat and threatened to kill her.

7. During my childhood, my aunt witnessed several incidents of inappropriate behaviour by mum toward me. I remember one particular occasion when my aunt threatened to take me home herself if mum did not, as it was clear I was very unwell. I was later diagnosed with glandular fever and should not have been brought out at all.

8. My aunt told me that she had seriously considered taking me in herself or involving the authorities, but she was dissuaded by other family members and her own experience with the care system. She concluded, on balance, that I would be better off with mum than in care.

9. In her opinion, my aunt believed that mum likely had a personality disorder.

<u>An account from my father regarding the development and circumstances of mum's mental health</u>

10. After mum's passing, my dad spoke with me about his relationship with her. Dad was a gentle, non-confrontational man; he remained loyal and supportive throughout all of mum's struggles with her mental health, even though he did not always understand her reactions or actions. Despite the knock-on effects, such as isolation from friends and family and the inability to reach or reason with mum or meet her need for support, he never wavered in his support.

11. He told me that their courtship and the first few years of their marriage were good. However, he said mum was often very emotional, which he attributed to her childhood difficulties, as confirmed in mum's medical records at page 612 which notes that mum *"..had been ruminating about a difficult childhood and becoming verbally aggressive to her husband…".* Dad recalled that after about two years of marriage, he began to notice a cycle of Mum withdrawing from him, seemingly without any obvious trigger.

12. The withdrawal would take the form of ceasing verbal communication and refusing to interact on any level. Dad said he often pleaded with Mum to talk to him about what

was upsetting her. These pleas were often met with rage, blaming him for her problems and accusing him of not understanding her. Over the years, I witnessed many of Dad's attempts to help mum and uncover what was troubling her. Later, I would try the same approach, encouraging her to talk but she was reluctant to engage. When she did, it was very one-sided: often angry tirades during which any input was impossible. Any attempt at input was met with accusations that I *"did not understand"* and that her issues were my fault.

13. The *"episodes,"* as dad called them, could last from a week to several months. He would patiently wait them out, and then, as if a switch had been turned on, things would return to normal, without any discussion or explanation.

14. On two occasions before I was born, dad said that mum left the home during these episodes, once with no explanation and once saying she was staying with a friend. Dad told me he was wracked with worry during those times, unsure where she was and feeling unable to confide in anyone. On both occasions, mum returned after a few days with no explanation and carried on as if nothing had happened. Even after 64 years of marriage, she never explained these absences, and dad admitted he was too afraid of her reaction to ask.

15. On one occasion, dad said they went on holiday to Bournemouth and had a lovely time. However, on the return journey, Mum suddenly stopped talking and interacting with him. This episode continued after their return home and lasted a couple of weeks. Again, it ended suddenly and without explanation.

16. Dad also spoke of mum's obsessive wish to have children. She insisted that everything had to be perfect before bringing a child into the world. However, after my birth, it was clear that mum was overwhelmed and could not cope. She told dad that she didn't want me anymore, claiming I was making her ill. In assessments and medical records, mum described her struggles after my birth, using this as an explanation for our relationship difficulties, especially when compared with her more positive experience during my sister's birth a few years later.

17. From as early as I can remember, mum's difficult experience of my birth and its supposed impact on her, was told to me and others repeatedly. In her rages, she would tell me that I was the cause of her mental health struggles. Dad said he struggled to cope when I was born. Mum wanted him to stay at home, but he had to explain he

needed to work to pay the mortgage and bills. He did his best on evenings and weekends to support her, even taking me to work with him when I was little more than a toddler.

18. Mum sent away the midwife assigned to visit after my birth, claiming her sister, who was a midwife at the time, was looking after her, this was not true. My birth clearly threw everything into crisis for both mum and dad. It was not a happy time. Many years later, as postnatal depression became more widely recognised, mum referred to herself as having suffered from it, which is noted at page 588 of her medical records, that *"…she had a second child and suffered from post-natal depression…",* though it had never been diagnosed or treated in the 1960s. However, in a letter to her GP, mum confirmed that when she was 30, about three years after my birth and one year after my sister's, she sought help from her GP for low mood, and treatment for depression began, continuing for the rest of her life.

19. Dad described a gradual decline in mum's mental health over several years, culminating in the crisis that led to her admission to Ruby Ward. The family noticed this too. She lost interest in all her hobbies which included music, the radio, and gardening.

20. Both dad and I tried to encourage mum to engage with them again, but she wouldn't. She no longer wanted to go on holidays, which she had once loved. It became difficult to get her to go out or attend family events.

21. Household chores became a struggle. My sister began helping with this, but she became unwell, so a cleaning company was engaged every fortnight. Initially, mum supported this but soon began to complain that the cleaners were too young, laughed and chatted, and irritated her, so she cancelled the service. Mum insisted she could cope and no longer wanted strangers in the house. Dad took on heavier tasks like hoovering and cleaning the bathroom, while mum dusted and cleaned. This arrangement seemed to work.

22. In the mid-2000s, dad had a couple of serious falls, which left him unable to do much while he recovered. Mum didn't drive, so I stepped in to help with shopping and doctor's appointments. When asked, mum always said they were coping and would let me know if they weren't. After the falls, dad employed a gardener/handyman, which worked well, at first, though mum would sometimes shout and bawl at him, which embarrassed dad.

23. During COVID, mum and ad had to shield due to dad's Chronic Obstructive Pulmonary Disease (COPD). My sister and I organised shopping deliveries. This continued even after it was safe for them to go out, at mum's request. However, mum would often complain about the deliveries but refused to accept our offers to take her shopping. She gradually became more obstinate, critical, and reclusive.

My observations regarding mum's mental health development

24. Mum's childhood problems were well known to me and the rest of the family. Even as a young child, I would be made to listen to her tirades about these issues, something that continued throughout her life. Especially in the months leading up to her admission to Ruby Ward, these became obsessive. As mentioned earlier, we were expected to listen but not intervene.

25. Any attempt to offer help or insight would be met with *"you just don't understand"*, followed by an aggressive outburst and withdrawal. We all learned to stay silent and let her finish on her own terms. These tirades always covered the same themes.

My childhood and recollections

26. During my childhood and adolescence, the cycles of withdrawal, rage, and emotional shut-down described by mum's sister and dad were common. These episodes could affect the entire family or, more often, be directed intensely at just one person, while others were treated normally.

27. Mum would often retreat to bed for long periods and refuse to be disturbed. As a child, I had to fend for myself or follow detailed instructions on cooking and cleaning. She would also rage uncontrollably.

28. I was hit sometimes with a stick, a wooden spoon, or a hairbrush and locked in my room for hours with threats of further violence if I tried to come out. Food would either be withheld or forced upon me as punishment.

29. Mum was obsessed with my health. As a child and adolescent, I was taken to the GP many times without understanding why. I was often forced to take medications or stay in bed all day, despite not feeling ill. Ironically, when I was genuinely unwell, it could

be incredibly hard to convince her, even when other family members pointed out how sick I was.

30. Mum struggled to maintain relationships with friends, neighbours, colleagues, and extended family. She would often form intense connections that fizzled out or ended badly. Afterward, she would smear these individuals and refuse to speak of them again.

31. My relationship with mum broke down in spring 1981 when I was 19. After months of her silent treatment, for reasons I never understood, I was gradually pushed out of the family dynamic. I became isolated, confused, and unhappy, spending as much time away from home as possible.

32. Eventually, after I failed to follow one of her cleaning instructions, she erupted. She grabbed me by the throat and screamed that she had never wanted me, that I must leave or she would kill me. I managed to escape, packed a few belongings, and fled, never returning.

33. Over the years, we both tried to repair the relationship. Though it remained difficult, things eventually settled over the last 25 years of her life. I gained some understanding of her mental health and tried to protect myself emotionally while continuing to offer support when I could.
34. It's important to say that, despite these serious issues, mum also had many creative interests that gave her solace and occasional connection with others. There were times she seemed to be managing well. In her own writing on mental health, she mentioned putting on a brave face.

35. As a child, mum often told me she suffered from depression. Her mood was frequently low, and even basic tasks were overwhelming. However, there were times when she became suddenly motivated, the house would be cleaned top to bottom, she'd work in the garden she loved and throw herself into her hobbies. There seemed to be a constant search for an external reason for her struggles, often with no reflection or insight. Blaming others, or giving up when support fell short, became the pattern. Happiness, for mum, came from others. If you failed to make her happy, you bore the brunt of her wrath.

Mum's family history of mental health

36. Mum's father suffered from what we would now call PTSD. He fought in WWI at Ypres and the Somme, was mustard gassed and shot, and was later diagnosed with "neurasthenia" (now recognised as PTSD). He was authoritarian and disciplined the children with a strap or slipper, something that deeply affected mum.

37. He told mum she was an unplanned pregnancy, describing her as the *"scrapings of the pot."* By the time I was born, her parents' marriage had broken down in all but name. Though they still lived together, they did not interact, and her father spent much time staying with other relatives or friends. Mum and her father rarely interacted, and when they did, it was curt or antagonistic.

38. Mum's mother had grown up in a home marked by domestic violence. Research later revealed that mum's great-grandfather had committed suicide. Mum often berated her mother for not maintaining a tidy home, dressing poorly, and raising her and her siblings inadequately. She referred to her mother as *"common"* and had few interactions with her.

39. Mum blamed her mother for the trauma of her WWII evacuation, claiming it happened only so her mother could work. She and **her siblings were separated** during evacuation, lived in poor conditions, and suffered untreated lice and scabies, all at the age of four.

40. **Another individual told my Mum about abuse** suffered during that time. Mum claimed no recollection of being abused but remembered being pressured into leaving **[I/S]** alone with the perpetrator. She later feared she had dissociative amnesia and had been abused as well, believing this might explain her mental health struggles.

41. Mum claimed she was excluded from family outings and events. Her sister said mum often initiated this exclusion by refusing to participate. Mum believed her siblings were given more opportunities. Her sister said mum refused any offers of help or support.

When mum first came into contact with mental health services

42. Mum took medication for depression for as long as I can remember. She confirmed that treatment for depression began when she was 30, and she remained on medication right up until her admission to Ruby Ward in January 2021, amounting to around 55 years.

43. As far as I am aware, there was never a formal diagnosis provided by anyone other than the GPs who treated mum over those decades. There were no referrals from her GPs for specialist mental health investigations, nor were there many therapies offered, based on what I observed and what mum shared with me.

44. Despite this, several mental health-related appointment letters remained in her papers after her death. These include the following:

- A Depression and Low Mood questionnaire from 2006 (only the first two pages were completed, but they revealed something about mum's issues at that time);

- A GP referral to a specialist mental health nurse for assessment at Sutherland Lodge Surgery, dated 19th November 2007;

- A referral to Dr [I/S] a member of Dr. A's team at The Christopher Unit, The Linden Centre, dated 9th December 2008; and

- Subsequent appointments with Dr. [I/S] at the Linden Centre, Broomfield Hospital on 10th March 2009, and at the Crystal Centre, Broomfield Hospital on 8th March 2010, 13th December 2010, and 28th May 2012.

45. Additionally, there was a letter from the Mid Essex Hospital Services Psychotherapy & Counselling Service, dated 1st August 2010, requesting a survey questionnaire to be completed prior to mum's knee replacement operation.

46. To my knowledge, the only therapy mum ever undertook was family therapy involving myself and dad. However, mum did not engage with the sessions. If anyone, even the therapist suggested something she disagreed with, she would storm out.

47. Therapy was also arranged on a private basis, likely during the early 2000s. I believe mum initiated these private sessions herself rather than through her GP, as they were privately paid for, though the appointment letters mentioned earlier could suggest otherwise.

48. Mum would often speak to me in great detail about what she had told the therapist during those sessions. When I asked if she felt the therapy was helping, she appeared baffled and did not answer. Eventually, she stopped attending altogether, explaining that recalling her childhood issues and the **abuse another individual had suffered was** too painful to relive.

49. Mum was frequently concerned not only about her mental health but also her physical health. She would obsessively read about medical conditions she believed she was suffering from. While she did have several genuine physical health issues that were investigated and treated, many remained undiagnosed despite extensive medical intervention. Mum often expressed frustration and anger over treatments that she felt didn't work, and she became very angry with her GPs.

50. I believe mum overwhelmed many of her GPs with the sheer volume of concerns she brought to them. She would often argue with them and even changed GPs on at least one occasion following a falling-out.

51. A particularly lengthy letter to her GP **[I/S]**, written in 2006, outlined many of her grievances. During her mental health crises in 2018 and again in 2020 and 2021, mum would become verbally aggressive with staff and GPs at her surgery, shouting and behaving in a threatening manner.

52. Sometime between 2005 and 2010, though I cannot be sure, mum began using opiate patches for arthritis pain following a referral to a pain clinic by her GP. Initially, the patches worked well, providing significant relief. However, over time their effectiveness waned, and her GP, reluctant to increase the dosage further, suggested that she begin to taper off their use.

53. During the withdrawal process, mum's physical and mental health deteriorated rapidly. She took to her bed, sleeping constantly and complaining of persistent pain and nausea. Dad became extremely worried and contacted the GP, who conducted an

emergency home visit. The GP concluded that mum was in full opiate withdrawal and prescribed a seven-day course of diazepam.

54. After the GP left, I visited mum on my own. She confided in me that she was having suicidal thoughts. She told me that when I was a child, she kept a knife under her pillow and had wished for the courage to use it, as she no longer wanted to live. She said she felt the same way now and asked if I would help her end her life to relieve her misery. This was deeply shocking and upsetting for me. I told mum firmly that I would not help her take her own life and reassured her that she would get through this with our support. Thankfully, she did.

Assessment

Police interactions and mental health assessments in relation to admission for inpatient care

Police incident – end of November 2018

55. In late November to early December 2018, mum experienced a serious and marked deterioration in her mental health. I was away on holiday at the time, so the details I present here are based on the accounts of my dad and sister. For more detail, regarding the police incident, I refer to my fax to mum's GP practice, Stock Surgery dated 27th December 2020, which outlines the similarities between this 2018 incident and the crisis of 2020–2021. Also relevant is dad's draft witness statement prepared for Birketts LLP, where he briefly describes this event.

56. At the time, mum had requested a change in her antidepressant from Citalopram to Fluoxetine. During the transition, tapering off the old medication and starting the new, mum suffered a severe episode. She became angry and aggressive, increasingly preoccupied with her past traumas, and unable to acknowledge that her family was trying to help.

57. Eventually, she walked out of the bungalow she shared with Dad. Concerned for her safety, my sister called the police. An urgent alert was issued to find mum, who had been reported as a vulnerable adult. She returned home on her own but remained highly agitated, shouting and being verbally abusive to both dad and my sister. When the police arrived, they spent considerable time speaking with her and were eventually

able to persuade her to attend Broomfield Hospital A&E for a mental health assessment.

58. We were never informed of the outcome of this assessment. Broomfield Hospital A&E declined to change her medication and released her into my sister's care, advising that the GP should handle any medication adjustments.

59. The following day, my sister took Mum to the GP, who prescribed Sertraline. However, Mum was extremely agitated and verbally abusive to the GP and staff at the surgery.

60. The only follow-up arranged was an appointment with an elderly care consultant, Dr [I/S] and his team at Broomfield Hospital on 13th December 2018. I attended this appointment with mum, my sister, and dad. Dr [I/S] concluded that little could be done at his level and recommended a referral to mental health services. He warned, however, that the service was overwhelmed and that mum was unlikely to be seen quickly. Mum, seeing no hope in the system, declined the referral.

61. Although Sertraline appeared to stabilise mum slightly, dad later noted (see his draft witness statement for Birketts LLP) that over the next two years, her anger and resentment intensified.

62. I observed a change in her mental state as well, with her previously episodic withdrawal and rages evolving into a persistent low mood, coupled with irritability and aggression. This continued until the autumn of 2020.

November 2020 to January 2021

63. During this period, mum began once again to question the effectiveness of her medication. I spent time discussing her concerns with her. She was fixated on returning to a digestive medication that she admitted had been ineffective in the past and soon became preoccupied with changing her antidepressant. She showed me a newspaper article about Mirtazapine and became convinced it would lift her mood.

64. Mum approached her GP, who agreed to transition her from Sertraline to Mirtazapine. According to mum's diary, the withdrawal began on 26th November 2020, and she took her first 15mg dose of Mirtazapine on 4th December 2020. By 11th December, she had developed physical symptoms, possibly from a reaction between Mirtazapine

and the Codeine she was also taking. She was initially prescribed soluble tablets, but these were changed to standard ones on 17th December due to side effects. By the time she was admitted to Ruby Ward, her Mirtazapine dose had increased to 30mg.

65. On 17th December, at mum's request, I joined a phone consultation between her and her GP, Dr [I/S] mum explained that her mood was still low but said she felt energetic, even noting that she had cleaned the house. However, both dad and I observed continued signs of manic behaviour, agitation, and irritability (as detailed in dad's draft statement for Birketts LLP, which covers the eight weeks leading to mum's admission).

66. Due to COVID-19 restrictions, families in Essex could not gather on Christmas Day. It was agreed that I would deliver a Christmas meal to mum and dad, which they could reheat. When I arrived, dad answered the door and took the food. I could hear mum shouting from inside. When I asked how things were, dad said he was *"okay"* and that mum was *"the same",* showing no improvement. He appeared dishevelled and had lost weight. It was clear to me that neither of them was okay.

67. Due to the restrictions, I had not seen them in person for at least three weeks. Dad quietly asked me to leave, fearing that my presence would escalate mum's agitation. The shouting inside grew louder, and I left.

Police and ambulance service incident – 26th December 2020

68. My below recollection of this event, is drawn from my fax to Mum's GP Stock Surgery, dated 27th December 2020.

69. By this point, we believed mum was in a full mental health crisis. She was overwhelmed by distress, unable to manage her emotions or interact meaningfully with those around her. That evening, I visited my parents with my husband. We found mum isolated in the conservatory, refusing to enter the house or speak to dad.

70. Dad, who has always avoided confrontation, had been enduring mum's behaviour in silence for years. He was clearly distressed and embarrassed, but hesitant to raise concerns, knowing mum would lash out if confronted. He feared making the situation worse by intervening, and this reluctance made it difficult to escalate the matter appropriately.

71. I sat with mum for an hour, listening as she spoke in detail, again about past traumas and perceived injustices. While I empathised and acknowledged her pain, I told her I was concerned these thoughts were overwhelming her and suggested she consider speaking with a medical professional. This suggestion triggered a hostile response. She shouted, *"I'm not mad!"* and *"everyone thinks I'm mad!"* Despite my reassurances, she was unwilling to accept help.

72. When I asked whether the Mirtazapine was helping, she defensively insisted that it was. However, her agitation and erratic behaviour suggested otherwise. She began verbally attacking dad, who remained passive, and then ordered my husband and me to leave. She also tried to push dad out, accusing him of threatening suicide. The situation was incredibly distressing. We begged dad to leave with us, but he refused, fearing what mum might do if left alone.

73. We called 999. The police redirected us to the ambulance service, which said they couldn't act immediately. Hours later, a paramedic phoned. I explained the situation and mum's mental health history. The paramedic spoke with both mum and dad, confirming that mum had been verbally aggressive and had physically jostled dad into the porch. Still, dad refused to leave, deeply worried for mum's safety.

74. The paramedic agreed to escalate the issue to the out-of-hours GP service. A call did come through at around 10pm, but the connection failed when dad answered. The paramedic later suggested that a Community Mental Health Order (CMHO) might be appropriate, as it would provide more structured oversight of mum's care, particularly around medication changes and emergency evaluations.

<u>Further Incidents and GP Involvement – Early January 2021</u>

75. On 4th January 2021, I sent another email to mum's GP (included in the appendix). We had still received no response following the urgent fax I sent on 27th December 2020. Then, on 2nd January 2021, a particularly alarming incident occurred. Dad found mum completely unresponsive and feared she had died. He sought help from neighbours, a nurse and a police officer, who managed to rouse her. Mum responded with a furious verbal assault, ordering them to leave and directing abusive comments at dad.

76. The police officer advised Dad to call 999 if he ever felt unsafe. At this point, both dad and the wider family believed this may have been a suicide attempt.

77. On 5th January 2021, mum's GP made a home visit, spending more than an hour trying to speak with her. Although the GP tried to calm her, mum remained unreceptive. Dad spoke briefly with the GP as she left, but no clear plan was communicated.

78. It wasn't until much later that we became aware of a letter sent on 6th January 2021 by mum's GP to Dr **A** at the Crystal Centre, requesting that a community mental health worker visit mum and dad at home. We did not receive a copy of this letter until it was released to us on 15th February 2021, after mum's admission to Ruby Ward. We do not know the outcome of this referral.

79. Over the next ten days, mum's mental health continued to deteriorate. She remained highly irritable, aggressive, and manic. Throughout this time, the family remained deeply concerned for both mum's and dad's wellbeing.

Admission

Police Incident, Overdose, and Admission – 18th January 2021

GP Actions

80. After mum was admitted to Ruby Ward, Mum's GP agreed on 15th February 2021 to supply us with written evidence of the actions she had taken in the run-up to mum's overdose and admission. (I refer to the email thread between mum's GP and EPUT's Access Team, run by Dr **[I/S]** on 18th January 2021, the day of the overdose and hospital admission.)

81. On page 3 of the email, there is a reference by mum's GP to an assessment carried out over the phone with **[I/S]** on 7th January 2021. Mum was allocated to IAPT (this, we later learned, was a downgrade from the GP's request for Access and Assessment), having concluded that mum's symptoms were relationship-based and not mental-health-based, despite noting *"pressured speech"* and *"flight of ideas."* The GP's observations on 6th January 2021, shared with Dr **A** do not appear to have been shared or acted upon.

82. The email thread with the Access Team developed following a phone call earlier that morning between mum and her GP. Mum had also spent time speaking to the Samaritans. Dad spoke with the GP on the phone and described mum's insomnia, shouting, and crying, as well as an incident at Whitley House where I took mum and dad for their first COVID vaccine. I observed mum's behaviour to be very paranoid (refer to dad's draft witness statement prepared for Birketts LLP, which gives his account). Mum's GP felt there were increasing signs of *"paranoid ideation"* and *"possible manic features"* in her behaviour and believed mum needed anti-psychotic medication.

83. The Access Team had downgraded mum from Access and Assessment (AAS) to IAPT following **[I/S]** assessment. They advised the GP to call 111 for crisis team support. The GP agreed to reintroduce the referral to AAS.

84. I called mum's GP once I had dad safely at my home and informed her of the police incident, which I describe later in my statement and of my serious concern for mum's safety. Mum's GP told me to call 111 if the situation worsened. I explained I was at home looking after dad, who was very distressed, and could not monitor mum's condition. The GP confirmed she would call in the Access Team that evening to visit mum at home.

85. At 16:12, mum's GP emailed the Access Team to confirm that mum had called the surgery, reported that she had overdosed, and that the GP had called an ambulance for her.

86. Although the GP overall acted in mum's best interests by contacting the Access Team, the Team's decision to downgrade mum's referral following a phone assessment on 7th January 2021, was not communicated back to the GP. The GP had provided a detailed assessment to Dr **A** the day before, which mirrored some of the Access Team's observations. Nonetheless, they still downgraded the referral. This lack of communication contributed to a failure in coordinated care.

Police Actions

87. Around noon on 18th January 2021, Mum locked Dad outside the house again, something that had happened several times before. A neighbour took dad into his home and tried to get mum to open the door. When she didn't respond, the neighbour

called the police just after midday. (Refer to Essex Police Crime Report 42, EP-20210118-0459. Although I am named as the informant, this call was made by mum and dad's neighbour.

88. Police called me to explain the situation. Since I had a key to the property, it was agreed the officer would meet me at mum and dad's house to avoid forced entry. I do not recall the officer's name, but the report states Officer **[I/S]** was the attending officer. He was alone and had no backup available, so he told me I would need to accompany him inside. I expressed fear for my safety and concern that mum might have attempted suicide. She had been extremely aggressive and intimidating, but the officer reassured me I would be safe with him.

89. Inside the bungalow, the officer found mum in bed. She was difficult to rouse; she briefly opened her eyes, then closed them again without responding. The officer asked if she was alright but got no answer. He left the room and asked me to speak with Mum while he made some phone calls.

90. I pleaded with mum to let us help her, that she needed to engage with health professionals. She remained motionless, eyes closed and covered her ears. She did not speak to me or to the officer at any point. I became so distressed I began to cry and struggled to breathe, fearing a panic attack. I left the room and found the officer in the kitchen. He told me that a mental health assessment was scheduled for the next day. This assessment, this was possibly the Health in Mind phone appointment dated 19th January 2021, later found among Mum's belongings.

91. I asked how we could ensure mum's safety until then, as I had no information about who was doing the assessment, whether it would be in person, or what time it would be. The officer didn't know. He said he believed mum was safe to be left alone and suggested I take dad home with me, as he had previously been locked out.

92. In a state of shock, I collected dad from the neighbour's home. The officer did not attempt to speak with dad and left. A few hours later, we learned that mum had overdosed and was being taken to A&E at Broomfield Hospital.

93. The officer's failure to speak with dad meant I only later discovered that mum had hit dad over the head with a remote control, bruising his arm, and had threatened to kill him during the early hours of 18th January (see Dad's draft witness statement to

Birketts LLP for further details of this incident). This was the third incident I was aware of where mum had lost control and made threats of violence.

94. Dad was deeply distressed. He told me he could no longer cope and feared for his safety. He later admitted to Essex Police and Social Services that he had contemplated suicide himself, feeling he had no way out. As dad says in his draft statement for Birketts LLP: *"I would like to spend what time I have left in peace, and without worry and fear for my safety."*

95. Although he understood mum was in crisis and needed urgent help, he wanted protection from her violence and threats. This was clear to the entire family, and we all worked tirelessly in the months that followed to get mum the help she needed and dad the protection he deserved.

96. Police failed to properly assess either mum or the situation on 18th January 2021, by not offering help or taking Mum to a place of safety. This inaction allowed the crisis to escalate. The email thread between EPUT's Access Team and mum's GP shows there was ample reason to be alarmed. Some immediate action should have been taken.

A&E, Broomfield Hospital – 18th January 2021

97. Mum's GP phoned me to inform me that mum had overdosed and was being taken by ambulance to A&E. That evening, I received a call from **[I/S]** senior psychiatric nurse working under Dr **A** consultant psychiatrist, to collect background information. I provided full details and emphasised our urgent concerns for mum's safety and for dad's as well.

98. **The nurse** confirmed that an assessment had been completed at A&E (see assessment data). Mum had agreed to a voluntary admission to Ruby Ward at the Crystal Centre for further assessment and treatment. He said this could take a couple of days to arrange, but that mum would remain on a medical ward in the meantime.

99. He also noted that if mum had refused voluntary admission, they would have pursued a section. As part of the assessment, he advised that there be no family contact for at least 14 days. At this point, COVID restrictions were in place. Given the threats and aggression, dad did not want contact, and other family members also needed to prioritise their own wellbeing.

100. For the first time in months, the family felt some relief. We felt we were finally being listened to, that mum would now receive care and be kept safe, and that long-term treatment might help resolve her struggles.

101. Mum's GP later provided us with a letter from Dr A, dated 20th January 2021, following her assessment of mum after the A&E overdose. This comprehensive report gave a diagnosis of Bipolar Affective Disorder, current episode mixed (ICD-10 F31.6) (see assessment of Consultant Psychiatrist, Dr A dated 20th January 2021). This diagnosis aligned with the family's own observations. Dr A also discontinued Mum's 30mg dose of Mirtazapine.

102. It should be noted that mum's family was not informed of this diagnosis at the time, we only learned of it on 15th February 2021, when Mum's GP confirmed it and provided all case correspondence.

Admission to Heybridge Ward and Ruby Ward – 20th January 2021

103. The following contains the family's evidence surrounding events, observations, and recollections at the time, corroborated with mum's medical records from Ruby Ward, assessment records, etc., which were released to me on 9th July 2021.

104. On 20th January 2021, the Ruby Ward drug chart shows Lorazepam 0.5mg and Olanzapine 2.5mg prescribed (noted in Patient Safety Investigation report (PSI) as 500mg). This is corroborated by PSI dated 28th July 2021, at page 19, which appears to show a discrepancy in dose. It is unclear for how long these medications were prescribed from the drug chart, or if gradual withdrawal was carried out, but the medical record confirms at page 106, *"stop Olanzapine"* with no explanation recorded. Both medications were withdrawn by clinicians on Ruby Ward by the time of discharge, without explanation or evaluation in the records. Why?

105. The medical records from admission and beyond discharge show *"manic depression"* as mum's diagnosis, even beyond 27th January 2021, the date of Dr B's review. In this review, he seems to point towards personality disorder as mum's diagnosis, yet the records continue to show *"manic depression."* At no point does Dr B appear to formally record Borderline Personality Disorder (BPD) in the medical records or explain this change in diagnosis. However, in a telephone call with

me on 22nd January 2021 (details of which will be described later), Dr B confirmed his diagnosis as BPD. Eventually, Dr B confirmed this diagnosis of BPD (emotionally unstable) to the PSI investigation team, and this is recorded within the PSI at page 21.

106. Mum was admitted to Heybridge Ward from A&E, where she spent two days. During this time, my sister and I called the ward to inquire about mum. The ward staff nurse (according to mum's records, this was [I/S]) told us that mum was very unwell and had caused concern due to disruptive and aggressive behaviour. Mental health services had been called in to assist (medical records show this was a senior nurse). It was agreed that the family would supply mum with comfort items she did not have. The ward sister suggested these items be taken to Ruby Ward as mum would soon be transferred there.

107. On 20th January 2021, mum was admitted to Ruby Ward. From that point until after mum's discharge, her records continually state she was suffering from *"manic depression."*

108. On 21st January 2021, mum was recorded as *"verbally aggressive and hostile,"* requiring a behaviour and intervention form to be completed by staff (see medical records for further information).

109. On the same day, mum was assessed by OT [I/S] (see medical records at page 134). Mum was observed as dominant in conversation and spoke about *"the episode where she became verbally aggressive towards her husband."* She also falsely indicated that dad had cognitive impairment and claimed to be his carer, which was untrue. Mum's irritability was triggered when discussing her aggressive behaviour the previous night towards staff; she then *"strongly denied"* that the incident occurred.

110. On 22nd January 2021, *"pressured speech at times"* was noted. Mum was also *"irritable at times and demanding of staff's time"* (see medical records at page 132). Mum also claimed that dad had mental health problems, which was false.

111. Dr B assessed mum with [I/S] recorded by his secretary [I/S] [I/S]. He noted that he had spoken with me and dad but did not record anything from these conversations, despite my call lasting nearly 30 minutes. A telephone call

between Dr B and Dr A also appears to have been redacted from the medical records.

112. Dr B's assessment described Mum as a *"challenging personality,"* impulsive, short-tempered, and defensive. He also noted, *"she is ambiguous in her history,"* which the family agrees with. However, there are falsehoods and confusion surrounding mum's recollections that are not corroborated by the family, for example, dad was hit with a remote control while it was still in mum's hand, causing bruising that lasted for weeks and was photographed by police. It was not thrown, contrary to mum's account.

113. Dr B recommended a safeguarding meeting, but at his review on 27th January 2021, he only noted, *"safeguarding raised on Mrs Reditt yesterday",* which was a delay of four days.

114. On 23rd January 2021, mum complained that *"no one wants to listen to her"* and expressed dissatisfaction with meals and medication. She appeared anxious and un-reassured by staff.

115. Between 24th and 27th January 2021, records show some improvement in mum's mood and interactions with others.

116. Olanzapine and Lorazepam appear on the ward's drug sheet. According to the medical records, Olanzapine was not stopped until 3rd February 2021, 12 days after admission, so these medications were presumably taken during this time, possibly indicating some positive effect on Mum's mood.

Ward Environment

Ward review 27th January 2021

117. On 27th January 2021, Dr B organised a ward review with Dr [I/S] [I/S] [I/S] (Dr B's secretary), [I/S] (adult social care team manager), [I/S] [I/S] (ASC), and [I/S] pharmacist. The facts and conclusions recorded by Dr B do not record or confirm the diagnosis given to the family of BPD. (N.B. manic depression still appears as the only diagnosis on the medical records).

118. The whole tone of the ward review is very scathing towards mum's family and not in the same tone as his first assessment on 22nd January 2021, with glaring contradictions. The following are the issues identified by mum's family; much of which is directly corroborated by the medical records. Dr B's ward review is also factually incorrect and in direct contradiction with his colleague Dr A and mum's GP, who both assessed mum, and the family's observations of mum's behaviours, but these observations were never recorded by Dr B

119. Prior to Dr B's ward review on 27th January 2021, he had phoned me on 22nd January 2021. Based upon notes I had made at the time, Dr B told me he had spent 3 hours with mum and an hour-long call with dad before calling me (the contents of the calls to both dad and I are not recorded by Dr B.

120. I was told mum had developed defences caused by anxiety which led to aggressive behaviours; she must always win, this behaviour is an ingrained habit, will not change, and will likely get much worse as she ages. When pressed for a diagnosis, Dr B confirmed BPD but stressed this was not a mental disorder and no manic or psychotic observations had been made.

121. Mum does not have a psychoanalytical mind, so therapy will not work, and Dr B did not wish to place a therapist in a position where they would be manipulated. The overdose I was told was to seek attention.

122. Dr B also said medication will not work, as depression and anxiety medication have a limited effect to dampen symptoms. He said he had removed all medications and will not treat mum. Dr B then said BPD is not a mental health disorder so mum cannot be sectioned for her own safety or that of others.

123. I was so shocked and alarmed that I contacted the charity Mind UK, who were equally as shocked as me. Mind UK's legal department confirmed that a mental health ward should be able to treat all diagnosed mental health issues and that BPD is a type of mental health issue diagnosed in Psychiatry.

124. Mind UK felt that the Mental Health Act is appropriate if a person is likely to harm themselves or others, which applies to all mental health issues diagnosed in Psychiatry. They confirmed that there were treatments for BPD, including Dialectical Behaviour Therapy and Mentalisation Therapy, details of which are available on the

NHS website. Their conclusion was that, as mum's mental health issues could not be managed, she was clearly a danger to herself and others and therefore could and probably should be sectioned.

125. Dr B states in his ward review *"admission after altercation with husband,"* mum *"barricaded herself in her house and locked her husband in garage"* (outside). This is factually incorrect, as mum was admitted following an overdose that was fully recorded by Dr A in her assessment. Dr A in her assessment on 19th January 2021, made observations of suicidal ideation, at pages 142 to 143 of mum's medical records.

126. Dr B also does not mention Dr A's diagnosis of *"bipolar disorder" "manic depression"* or offer explanation for his difference of opinion with diagnosis. Dr A had recommended escalation: *"full active treatment," "admission to stabilise her mood is needed in a supervised environment before community care can be considered."*

127. Dr A observed that mum was *"presenting with a mixed affective picture," "she is irritable and pressured and manic in her presentation with suicidal thoughts," "speech is mildly manic."*

128. Dr B stated mum is not known to mental health services, which is factually incorrect. Dr A correctly records *"history of mental health care under the Access and Assessment team see notes,"* and she also confirms an A&E assessment in 2018.

129. Dr A's conclusion is *"there is a potential and chronic event of misadventure remains given pattern of long-standing risk."* This is all in stark contrast to the comments Dr B makes in his ward review.

130. Dr B also stated that it is *"unlikely to be a mental health issue," "this is not a mental health issue," "we are not treating her in any way," "she has personality issues rather than mental health issues, these are treated by psychologists not mental health personnel."*

131. On 22nd January 2021, at 17:38, a phone call between Dr A and Dr B took place (Page. 130 of medical records) where Dr A tells Dr B

that *"she is presenting with a mixed affective presentation having been admitted following an overdose,"* "*then presenting as irritable and hypomanic," "it is my view that this lady would be a significant risk to herself and her husband and that consideration should be given to detention under the Mental Health Act if she tried to leave."* Dr **B** ignored Dr **A's** points regarding risk and treatment.

132. On 22nd January 2021 at 17:01, a further review was carried out by **[I/S]** and a support worker (Page. 130 of medical records) which records that mum had *"developed a challenging personality where she is impulsive, short-tempered, defensive; she is ambiguous in her history," "she is still cross with her husband, and this may escalate if she goes home now."* Risk to dad is recorded.

133. Although Dr **B** states that family are *"supportive,"* he goes on to say that we do not want mum home. Mum's family have explained on more than one occasion their clear fears for mum and dad's safety following many incidents and that mum's family could not keep her safe or cope with her behaviours. Dr **B** had recorded the threats to kill dad in his assessment (see assessment on page 131 of medical records dated 22nd January 2021) and family concerns that dad must be safeguarded, but he takes no action.

134. The family were never offered any assurances that mum was treated, that she understood her diagnosis, and that she could manage it in the community; no discussion was ever offered to see how, as a family, we might be able to help mum.

135. Bearing in mind we had told Dr **B** our relationships with mum had broken down due to our real fears of her violence and aggression and our inability to reason with mum on any level. Dr **B** even goes on to say that there is *"no need for care in any sorts or social services input,"* he states *"we are in a family feud,"* which is utterly shocking. Dr **B's** observations and views are in direct conflict with those of all his colleagues and Mum's family.

136. Also, on 27th January 2021, it is recorded by **[I/S]** at page 119 of medical records, *"advice from WR (ward round) was that 'nursing staff are not to contact family until advised otherwise'."* It is noted that family have contacted PALS.

137. A very worrying, counterproductive, confrontational standoff seemed to be Ruby ward's way of dealing with this very complex and difficult situation. Following my

phone call with Dr B on 22nd Jan 2021, where Dr B confirms he will not treat mum, and mum needs to go home without any support for her and the family. We had no option but to complain and endeavour to seek advice to try and find a solution ourselves.

138. My sister approached PALS for advice verbally initially; this seems to have pushed Ruby ward to refuse to speak with us.

139. On 23rd January 2021, I made my first contact with social services; I was told to ring back on Monday.

140. On Monday 25th January 2021, I spoke with [I/S] regarding safeguarding for dad and that mum would be sent home with no treatment for her mental health crisis; she assured me she would call Ruby Ward straight away and discuss.

141. Later that day, I received a call from Ruby Ward's matron [I/S] she confirmed she had been contacted by social services and assured me that there would be a multi-disciplinary meeting on 28th January 2021 to discuss the safeguarding for dad, at which mum's family are invited (this was a Teams meeting at 3pm due to Covid restrictions).

142. On 26th January 2021, [I/S] social services rang to check that Ruby Ward had contacted me. Thereafter, the Teams meeting was cancelled by Dr B's secretary as Dr B had tested positive for Covid, and mum was in isolation following contact with him.

143. By 31st January 2021, mum was Covid positive and isolated until 9th February 2021. The meeting was therefore, rescheduled for 9th February 2021.

144. Later on 31st January 2021, a phone call from family was recorded for the first time in the medical records; many more calls were made than are recorded, wanting to speak with staff to inquire after mum's wellbeing. Often it was very difficult to get through to Ruby Ward, as the phone just rang.

145. On a couple of occasions when it was urgent that we spoke to the ward, we had to resort to contacting Dr B's secretary, leaving messages on her

answerphone. Communication was very poor. During the PSI, ward staff accused family of not contacting the ward, which was factually incorrect.

146. On 3rd February 2021, recorded on medical records is *"stop Olanzapine,"* with no explanation given, after it was apparent that mum had been taking Olanzapine for about 12 days at this point. It has already been recorded that there appears to have been some improvements in mum's mood between 24th January to 27th January with little recording of mum's previous aggression and irritability. This appears to continue up to 3rd February, so my question is why was Olanzapine withdrawn? Was it gradually withdrawn or just stopped abruptly and prematurely?

147. Olanzapine appears to be used to treat mania or mixed episode that is part of bipolar disorder (manic depressive illness); it must continue to be taken and withdrawn gradually under medical supervision. I would like the inquiry team to inquire, whether this happened? There also appears to be no explanation or evaluation of the effectiveness of the drug before withdrawal. Why? Again, I would like the inquiry team to investigate this.

148. On the same day, **[I/S]** conducted a ward review where she records *"mood settled," "no bipolar has been noticed."* Why was Olanzapine withdrawn when there appears evidence that it was helping stabilise mum's mood? Mum is clearly being treated for bipolar disorder (manic depression) in line with Dr **A's** assessment on admission. At this point, mum's family have been told mum's diagnosis is BPD by Dr **B**, which makes no sense to me.

149. Also, on 3rd February 2021, it is noted that Promethazine 25mg is introduced on a PRN basis (when needed).

150. On 4th February 2021, a referral is made by the ward for a care coordinator for CPA (care programme approach) and planning purposes, despite safeguarding still outstanding.

151. Later on 4th February 2021, I called Ruby Ward to speak about my decision regarding the invite from the ward made by them on 27th January 2021, to a video call with mum for my sister and me and a possible visit.

152. My decision is accurately recorded in the medical records at page 104 by [I/S] [I/S] Both my sister and I made our decisions individually to avoid contact with mum. Dr B had given no assurances that mum was in a better place and her mood stabilised, that the mental health crisis had been treated, and mum understood and could cope with her diagnosis for the future; in fact, he had told me he would not treat mum, and this is corroborated in the medical records.

153. We both did not feel that risking triggering the aggression and violence of the past months was in mum's best interest or ours, as it became evident that both my sister and I were struggling with our own mental health following the trauma that we had been through with mum. This culminated over time into PTSD for my sister and severe anxiety for me. We have both received treatment and therapy for these issues.

154. Dad, we were told, was excluded as Ruby Ward felt this would be triggering for Mum, so it appears that they were prepared to take this risk with me and my sister, which was alarming. It must be noted that the PSI investigation at page 30, does suggest that Mental Health Family Group Conferencing should have been considered to rebuild mum's relationships with her family before discharge; this was never explored by the ward.

155. On 8th February 2021, mum seems to have recovered from Covid and is out of isolation (although this is not recorded in the medical records). [I/S] OT carries out a one-to-one with Mum (Page. 95 of medical records). These are her recorded observations:

156. *"Dorothy dominated the conversation and was talking in tangents, difficult to bring back to original topic/question although pressure of speech considerably reduced."*

157. Mum goes on to speak about her childhood and struggles with caring for dad, which is factually incorrect. Dad was not incontinent and certainly was not in need of ADLs such as personal care.

158. Mum is asked how she will manage the situation in the future if she does not feel it will improve; Mum said she requires help at home. Whatever struggles mum had with dad, as far as her family observed, were those he endured whilst trying to cope with Mum's mental health struggles and the crisis of two months' duration.

159. Mum goes on to unfairly and inaccurately blame both myself and my sister for lack of support, after giving an accurate but unjustified reason for cancelling a cleaning package my sister organised to help mum.

160. It is evident that mum is very reclusive and unable to seek other interests, something mum's family observed. Dad and mum's family were never asked to corroborate the statements mum made about dad and his need for care.

Staffing Arrangements, Training and Support

Video Call Teams Meeting – 9th February 2021

161. Attendees at this meeting were Dr B (consultant), Dr [I/S] (higher trainee), [I/S] (ward manager), Dr B's secretary, [I/S] [I/S] (social worker manager for older adults), [I/S] (OT), Dad, myself, my sister, and her husband.

162. The meeting, we were led to believe, was a safeguarding meeting focused on how dad could be protected from mum's aggression and violence, and to find a workable solution for mum's discharge. (We would ask that the inquiry recall the phone conversation from Ruby Ward's matron on 25th January 2021, when assurances were given to this effect.) Unfortunately, it quickly descended into a heated confrontation, where we were expected to defend our position, rather than have it given proper consideration and discussed as part of finding a way forward.

163. From my notes of the meeting, mum's family spent a considerable part of the meeting giving a history, our observations, and events concerning mum's difficult behaviour, but this is not recorded. Dr B was obstinate in his view that mum's family must comply, agreeing to care for mum at home without any assurances regarding her mental health having been treated or stabilised, that mum understood and was able to cope with her diagnosis, what help would be available to support her, or how the risk of harm to dad could be resolved.

164. Mum's medical records at pages 90 & 91, record only some of what occurred and was said in what was more than an hour-long meeting, which we were told was being recorded, but later discovered (during the PSI) was not. What is recorded in the

medical records is out of context, not chronological, and contains falsehoods surrounding matters that can be corroborated to the contrary in the medical record.

165. It was offered for mum to join the meeting, but the family felt it was not appropriate, as it was a safeguarding meeting relating to dad. It was important to discuss the difficulties, and the abuse dad had suffered openly without the worry of triggering mum emotionally. Also, as previously explained to Ruby Ward, we had to consider and protect our own mental wellbeing, we feared triggering mum's aggression, and did not feel there were any assurances that mum would cope with a meeting of this nature.

166. Dr B states he *"recognised the challenges faced by the family,"* however, mum's family did not feel this was the case. He did not offer any solution or plan and became very defensive at any suggestion that the risks to dad must be considered and resolved, and proper assurances given that mum was well enough, supported, and it would be safe to discharge her, especially as he was not treating her at all.

167. We tried to explain the real impact of mum's behaviours on us all as a family, with details of historical events and the more recent crisis, the incredible manipulation, gaslighting, and unjustly blaming and shaming her family to get her way. Dr B had described just this type of behaviour to me during our phone call on 22nd January 2021, when he diagnosed mum with BPD.

168. Even at the meeting, Dr B describes and records: *"to protect her inner self she becomes defensive by lashing out before anybody can hurt her," "she has developed a personality where she gets defensive if people question her and can become aggressive if people don't agree," "Most of these aggressive episodes are limited to their family as they can control these urges,"* and that Mum *"can manipulate the situation."*

169. Dr B, although recognising these behaviours, had no offer of a solution or suggestions to manage them or support to do so, for either mum or her family. Mum was incredibly difficult to reason with. What should we do when mum resorts to violence and threats to kill? How could her family be expected to manage and mitigate the clear risk, along with the impact on their own mental wellbeing?

170. We made it clear: the family cannot keep mum safe or prevent her from hurting dad. However, worryingly, Dr B seems to think mum's family can control all these complex factors. Dr B accepts mum is manipulative but cannot accept it when we suggest that mum may be manipulating him. Dr B and his colleagues have recorded that mum finds recalling her history problematic and she runs off on tangents, getting confused and forgetting what she said. Surely this is enough to set him on guard regarding the accuracy of what he is told by mum. Many times in the medical records, mum's recollections are different and confused. Surely it is not possible to accurately recognise mum's behaviours, listen to their impact on her family and their limitations and concerns in managing them, and then dismiss the risks those behaviours pose, failing to even attempt to mitigate them.

171. Dr B also records: *"since her admission we have not seen any mental health disorder like mania, depression, psychosis, schizophrenia, dementia that requires acute hospital admission."* It is clear Dr B has not read Ruby Ward's notes, where his colleagues have recorded mania, depression (low mood) regularly, or taken on board any of the assessments done by Dr A at mum's admission, or heeded Dr A's advice in her phone call with Dr B on 22nd January 2021, noted at page 130, of mum's medical records.

172. Dr A describes a myriad of serious mental health observations, some being: *"suicidal ideation," "hypomanic," "pressured and manic,"* and her recommendation for *"full active treatment," "admission to stabilise her mood is needed in a supervised environment before community care can be considered," "in my view this lady would be at significant risk to herself and her husband if she returned home and that consideration should be given to detention under the Mental Health Act if she tries to leave," "a potential and chronic event of misadventure remains given pattern of long-standing risk."* Dr B is disregarding all his colleagues' concerns and opinions, as well as Mum's family's.

173. Dad gave a statement to the meeting, which is partially recorded in the medical records, where he described what he had been through trying to cope with mum's crisis. Dad made it clear he could no longer cope. It is recorded that dad broke down and cried as he recalled his abuse.

174. Dr B states: *"she is on a psychiatric ward but does not suffer from any mental illness that requires an acute hospital bed," "she is not detainable."* This again

contradicts Dr A assessments, her observations, opinions, and also the advice given by Mind UK legal department to me, as previously recorded.

175. Dr B confirms he will allow mum to leave and sees no reason for her not to go home, as she co-owns the house with dad. The family found this extremely confrontational. [I/S] (social services) stepped in to explain that safeguarding had been raised and was at present with EPUT and she would look into it. *"The assigned person will investigate the problem, discussions with family."* She and no one else knew who had been allocated the case. The outcome was never known to the family or social services and was still outstanding at the time of Mum's death.

176. It is not recorded here, but social services did point out that she felt sending mum home would be dangerous. In her experience, this just allows the aggressive behaviours to be reinforced, as the family is the trigger. Social services clearly trying to de-escalate the situation, reassured the family that everyone is the priority. She may have to escalate the problem to the police. She pointed out, "*we are all concerned about Mrs. Reditt and we need to make a decision which is beneficial to everyone."* Social services now appear to be taking on the responsibility for the safeguarding from Ruby Ward.

177. The issue of capacity was discussed. It was explained by the family that in crisis, mum cannot make decisions that are in her best interest, cope with day-to-day tasks, or be reasoned with, as she gets confused and irrational. Mum has confirmed in assessments how she cannot cope and becomes overwhelmed, and how she must rely on dad and her family to organise and make decisions for her. The family were under no illusion that mum was extremely vulnerable, and some sort of checks and balances should be made regarding her decisions, to ensure they were safe. We felt mum's capacity, from our observations, was questionable.

178. Despite our concerns and observations, Dr B disregarded them, suggesting mum was free to leave the ward if she wanted and he would not stop her.

179. Alarmingly, Dr B states and records that: *"we have found no evidence that she remains aggressive or took an overdose."* Again, these statements are factually incorrect. The medical records and Dr A's assessment confirm an overdose, and mum is recorded as offering confirmation of this more than once in the medical records.

180. Dr **A** lists what has been taken. The Ruby Ward records clearly show irritability and aggression over many days, with periods of low mood. The drugs Olanzapine and Lorazepam are not evaluated in the medical record, along with their effectiveness on mum's aggressive behaviours and mood, either while she was taking them or after they were withdrawn. There is therefore no evidence that mum's mood is stabilised, or her aggression effectively controlled.

181. The meeting ended without a solution to the issue of safeguarding. It appeared social services were now dealing with it. Despite no safeguarding being in place, Dr **B** records that he will let mum self-discharge and call the police, which was a totally inadequate way to deal with a complex situation of great risk for mum and her family. It now becomes even more necessary for mum's family to try and find a solution themselves and seek advice to aid this, as the ward seems oblivious to any risk.

Phone call from ward – 14th Feb 2021

182. By 14th February 2021, it is noted in the medical records by **[I/S]** at page 79, that *"she has remained here as asked by Dr* **B** *but feels that we are not acting in her best interests and would like some independent representation."* It appears that mum is starting to become disgruntled about several things and is beginning to complain to staff.

183. One of the issues, which escalated badly, surrounded several valuables that I had collected from the ward some weeks earlier at their request, as they did not have safe storage. Mum had signed for me to receive these items, and I countersigned on receipt. These items had all been given by me to dad for safekeeping and were no longer in my possession.

184. On 15th February 2021, dad received a call from Ruby Ward regarding these items. After the call, dad phoned me in floods of tears. It took at least 20 minutes to calm him enough to find out what had happened. He told me that someone from the ward, a man whose name he couldn't recall, had phoned and was insistent that these valuables, especially a set of keys to the home mum and dad had shared, be returned, as mum wanted to come home. Dad said this would compromise his safety and that this was supposed to be under investigation by the hospital and social services. He

refused to return the keys and compromise his safety until the investigations were completed and he knew the outcome.

185. Not satisfied with dad's answer, the phone was handed to a woman, and then to another man, both of whom reiterated the need to return the keys. Dad again had to confirm his reason for not doing so. They threatened dad with police action and became increasingly insistent when he stood his ground.

186. While I was calming dad, I received a call, but I couldn't answer as I was still on the phone with him. I assured dad I would deal with it. The missed call was from Ruby Ward, and I phoned them back. Like dad, I was confronted with a loudspeaker call involving several members of Ruby Ward. I asked for their names and was told they were Dr [I/S] Dr [I/S] Matron [I/S] and Dr [I/S]

187. Dr [I/S] began asking for the return of mum's valuables. I explained these could not be returned by me, as they were now in dad's possession, and it was his decision not to return them until the safeguarding investigation was complete. Like dad, I was passed between at least two other staff members who reiterated the need for the valuables to be returned. They seemed unable to accept that this was not something I was in control of. Dad had made his decision, and I told them I would support him in that. Threats of police action ensued.

188. I pointed out the safeguarding investigation and the agreement with social services at our last meeting to follow this up. I asked whether their investigations had been finalised an if so, what was the decision? We had not been informed. I was told the safeguarding investigation was still ongoing and that no decision had yet been made.

189. The Ruby Ward staff threatened to just send mum home. I pointed out that it was likely dad would not let mum in and would phone the police for protection, as is his right. I also told them that dad had expressed a wish to explore legal means to prevent mum from compromising his safety, following advice from social services. I said I believed this would be a clear breach of their duty of care for mum and placing her in an awful situation that was not in her best interests. I reiterated that the safeguarding issues needed to be resolved before mum came home.

190. It was a very heated and confrontational call, and I asked how they, as *"the caring profession,"* could justify blatantly bullying an elderly man who had been through an awful time of abuse, frightening him and bringing him to tears. I got no answer. I ended the call by confirming that I was to be contacted first rather than dad, and that I felt there was nothing more to discuss.

191. Ruby Ward, at page 77 of mum's medical records recorded this conversation. It must be noted that Dr [I/S] note surrounding the call to me does not confirm that they had phoned dad first and made him cry. Alarmingly, it is recorded that mum *"at present does not suffer from any acute mental illness and there were certainly no risks of harm to self or other that we have identified whilst her stay here."* Again, no heed is taken by the clinicians on Ruby Ward of Dr A's assessments, recordings by colleagues in the medical records of aggression, or the family's observations and experiences of aggression and violence.

Contact with Social Services – 15th Feb 2021

192. On 15th February 2021, I spoke to [I/S] social services. The following are the points we covered, and the advice given:

- Ruby Ward confirmed mum does not meet the criteria for residential care, but observations can be different on the ward compared to living alone.

- [I/S] asked if mum knows and understands that dad does not want to live with her anymore. I said I did not know what the ward had told mum or what her understanding was.

- [I/S] said managing mum's complex issues in the community could be difficult.

- Any care is means-tested, and assets in the home they shared can be used to fund this. She suggested dad speak with a solicitor regarding a non-molestation order, etc.

- Social services and the ward cannot stop mum from going home, but the police and my dad can.

- [I/S] said it was very remiss of the police not to speak with dad on the day he was attacked.

- She stressed that dad must not go back on his word and take mum back as this could be catastrophic. There would be no going back.

Care Management and Care Plans

Inpatient Care Plan – 14th February 2021

193. The plan of action, in which only three of the five pages appears in mum's records, clearly states: *"I am fully aware if I attempt to leave the ward at present due to the ongoing safeguard open that police will be informed, and I will potentially be held under section."*

194. Although the family had been told that mum was not being treated for mental health issues, Lorazepam 5mg, to be taken every 4 to 6 hours, is still being prescribed according to the drug chart. If it was withdrawn, this has not been recorded, nor has any explanation been given for its withdrawal.

195. It is suggested that outside help should be sourced to repair family relationships. However, this was clearly never actioned.

196. Safeguarding is mentioned in the plan but is confirmed to still be under investigation, with the ward manager noted to be responsible for liaising with appropriate teams to resolve the issue. This was evidently not done, as the EPUT safety investigation remained outstanding at the time of mum's death.

197. It is noted under *"Risk and Management"* that there is a *"risk of OD (overdose) when feeling neglected,"* along with *"self-neglect, vulnerability, emotional state."* This directly contrasts with Dr **B's** statements in meetings and entries in mum's medical records, where he confirmed that mum had not overdosed and that there was no risk of suicidal ideation.

198. The plan of action also states: *"I understand that until the safeguard is investigated, and we are aware of the outcome, I will remain here as an informal patient until it is resolved."*

199. It seems clear from this ward review that mum was to remain on the ward until the safeguarding investigation was completed, and that in the case of her attempting

to self-discharge, the potential for detention under section was to be considered. This raises the question: why, on the very same day, were Ruby Ward clinicians telling the family that mum must come home?

200. A further document in the medical records, marked as urgent and received by [I/S] on 15th February 2021, records mum's referral reason as *"in crisis."* The family was not made aware of this. Under the diagnosis section, it is recorded *"person aware of diagnosis?"* It is unclear what this specifically refers to, but mum's family had suspected that she did not understand her diagnosis.

201. Several statements written by mum also appear in the medical records, in which she ruminates on many subjects, refutes allegations of abuse towards dad, makes false accusations, and complains about various aspects of her experience on the ward.

202. On 16th February 2021 [I/S] (Occupational Therapist) recorded on page 74 of mum's medical records that she was *"becoming hostile and angry with staff."* She went on to make a detailed record of mum's behaviour, reporting that *"she is aware she is not mentally ill."* This again raises the question of whether mum truly understood her diagnosis.

Treatment

Treatment and PALS Complaint

203. On 16th February 2021, mum's GP provided the family with all correspondences concerning mum in the lead-up to her admission. This was the first time we saw Dr A's assessment of mum on admission to A&E and her diagnosis: *Bipolar Affective Disorder, current episode mixed (ICD 10F 31.6)*.

204. This greatly alarmed the family, as this diagnosis recommends full active treatment and records a significant risk of escalation in relation to mum's mental health. It also correctly documents the risks posed to dad. This is in complete contrast to everything Dr B and Ruby Ward had told the family. Primarily, the diagnosis differs from the one given by Dr B which was BPD (Borderline Personality Disorder).

205. On 16th February 2021, my sister submitted an official complaint to PALS via email. However, this was never effectively actioned, as it appeared that mum's permission was required to proceed with the complaint. PALS sent a letter to mum at her temporary accommodation on 11th March 2021, nearly a month later but she never signed it. This complaint, registered as 29363, was converted into the first PSI five days later following mum's death.

206. It is clear that the PALS system has no mechanism to action complaints made by anyone other than the patient without the patient's consent. This clearly needs to change. Often, a patient is not in a position to raise a concern due to their illness, whether physical or mental, and family members, carers, and friends must be able to raise the alarm and make a complaint on their behalf.

207. Ruby Ward conducted a ward review on 17th February 2021. The following is recorded: "Can often be rude and hostile"; "Dorothy has been racially abusive on the ward towards certain members of staff the past week"; "constantly changing the message she conveys (changing her statement often)." There is denial of any assault against Dad, and Mum casts untrue accusations against her family.

208. Mum was being regularly prescribed Zopiclone to aid sleep. This was introduced by an on-call doctor on 14th February 2021 (page 79 of the medical records), after complaints by mum of not sleeping, despite the records showing no documented evidence of insomnia. There are contraindications with this drug in relation to suicidal ideation. Suicidal ideation is clearly marked in mum's medical records. Therefore, I would question why this drug was prescribed to mum, especially as she later went on to use it in a further suicide attempt.

Individual Circumstances and Characteristics

209. Whilst considering my statement here, please also see my response under the *"Training"* section, but I will reiterate this point here.

210. Dr **B** records: *"since her admission we have not seen any mental health disorder like mania, depression, psychosis, schizophrenia, or dementia that requires acute hospital admission."*

211. It is clear Dr B had not read the Ruby Ward notes, where his colleagues regularly recorded mania and depression (low mood), nor had he taken on board any of the assessments completed by Dr A at mum's admission. He also failed to heed Dr A's advice given in her phone call with Dr B (at page 130 of the medical records, recorded on 22nd January 2021).

212. Dr A described a myriad of serious mental health concerns, some of which included *"suicidal ideation," "hypomanic,"* and *"pressured and manic."* Her recommendations included *"full active treatment"* and that *"admission to stabilise her mood is needed in a supervised environment before community care can be considered."* She added, *"in my view, this lady would be at significant risk to herself and her husband if she returned home, and consideration should be given to detention under the Mental Health Act if she tries to leave."* She concluded that *"a potential and chronic event of misadventure remains given [the] pattern of long-standing risk."*

213. Dr B appeared to disregard all of his colleagues' concerns and professional opinions, as well as those of mum's family.

Safety

Please note the below section on self-discharge, as the way this was handled directly affected the safety of Mum.

Leave, Absconsion and AWOL Patients

Self-discharge and police involvement – 20th February 2021

214. My email of 22nd February 2021 to [I/S] (Social Services) provides an overview of this incident from the family's perspective. It is reproduced here.

215. The incident is also recorded in Mum's medical records at page 64 by [I/S] [I/S] and on-call doctor [I/S].

216. It is noted by [I/S] that the ward will use the plan formulated by Dr B and the MDT (Multi-Disciplinary Team). The police are called; however, the plan fails at the first hurdle as the police refuse to attend or assist. It is recorded that it was necessary for the police to confirm to Ruby Ward staff that this matter was for

social care to deal with, not the police. It is not clear why social services were not called in by the ward at this point. My conversation with [I/S] at social services at the time of this incident seems to indicate that either the ward or the police could have called them, but they were unable to act without receiving instructions to do so. It is also recorded that the on-call doctor had not seen mum prior to her self-discharge, as the ward staff were not aware that this should be done.

217. It is recorded that on-call Dr [I/S] (registrar) manages to persuade mum to return to Ruby Ward and instructs that, in the meantime, nursing staff are to utilise Section 5(4) powers of the Mental Health Act (nurses' ability to detain for six hours), and inform the on-call doctor, who will then utilise Section 5(2) (MHA 72-hour detention). A Datix is triggered.

218. [I/S] (on-call doctor) records that he is informed by [I/S] that mum was to be let out of the building and the police called, in line with the plan from the ward review with the consultant and ward manager. The last ward review dated 17th February 2021 has only three pages, and I suspect it is incomplete. There is no reference in that review to procedures to follow if mum were to self-discharge. However, the Inpatient Care Plan dated 14th February 2021, clearly states that mum is to remain until safeguarding is complete, and that the potential for sectioning would be considered if mum attempted to leave. It also states that mum is aware of this plan. This contradicts the Ruby Ward's actions surrounding this self-discharge.

219. The records are confusing. It is recorded *"that it is recorded that there are safeguarding with her family",* which I assume this confirms that safeguarding concerns are outstanding. It is also confirmed by [I/S] that *"it will not be safe for her to leave the ward without a safe discharge plan,"* and that he *"will discuss the discharge plan with the ward team and consultant."* It is not recorded that this was done.

220. Following this incident, it is important to establish whether any of the following were followed up:

- Did [I/S] or Dr [I/S] discuss a safer discharge plan with the Ruby Ward consultant and ward team?

- Was the use of the MHA, as suggested by Dr [I/S] pursued as a tool to mitigate the clear risk to mum?

- What was the outcome of the Datix?

- Why was the Inpatient Care Plan at odds with the ward review to which [I/S] refers and which the ward followed in the event of self-discharge?

221. These questions are important, as the same scenario played out again on 4th March 2021, with no apparent modifications to the discharge plan.

222. On 22nd February 2021, dad receives another call from someone on Ruby Ward, insisting that he agrees to mum coming home. Dad is insistent that, until safeguarding is in place, he cannot, for his own safety agree. Again, dad rings me in tears after the call. This is clear bullying on the part of the ward. They have previously been asked by dad and during the family's most recent meeting, to refrain from doing this.

223. Mum's medical records at page 58 note that my call to Dr B's secretary, [I/S] (as no one on the ward was available to speak with me), in response to the call made to dad. The ward seems oblivious to the ongoing safeguarding matter with EPUT, which is still open, as well as the ongoing safeguarding work being done with social services. They appear unaware of the serious risks if this process is not properly carried out and mum is discharged without addressing the risks to both mum and dad.

224. Dad is increasingly being made aware by social services that any solution must now be legal. This saddens and upsets him, but he has come to the realisation that he can no longer live with mum if there is no hope of treatment or any clinical intent to resolve mum's mental health issues. This is not a decision he has taken lightly and up to this point, he has refused to take legal action, even when suggested by the police, as he felt it was not in mum's best interests. But the ongoing issues with conflicting diagnoses, leading to no treatment, forced dad down a route that may not have been necessarily had there been a more collaborative and accurate diagnostic process.

225. Fundamentally, the issue of misdiagnosis left mum untreated, extremely vulnerable to relapse and further mental health decline. Added to this was the prospect of having to navigate complex legal issues, a process which we, and social services (as reflected in their email communications to the family), believed mum was not in a

fit state to understand or manage. This is evident in the medical records, where mum's recollection of events becomes increasingly ambiguous and accusatory toward her family. Mum is also being placed in an unfortunate and deeply upsetting position where she is expected to deal with legal matters but is clearly struggling.

226. Mum's safety was now at the mercy of the poor support and evident incompetence of Ruby Ward in managing the ongoing risks surrounding her discharge.

227. The medical records continue to show that mum has no understanding of her diagnosis, which was repeatedly recorded as *"Manic Depression"* and that she is hostile, aggressive, and rude to staff, and uncooperative. When she hears a man screaming in the corridor, she is not reassured by staff that there are no male patients nearby. Mum is tearful, suffering from low mood, and remains unassured by anything staff do or say.

228. Clearly, from what the family can gather from the medical records so far, there has been no improvement in mum's mood or behaviour.

Self-discharge and police incident – 4th March 2021

229. On 2nd March 2021, mum asked why she was no longer being given her antidepressants and expressed that doctors were not listening to her concerns. Staff offered psychological input to discuss these issues, but it is unclear from the medical records whether this was followed up.

230. On 3rd March 201, a ward review took place. It is recorded that mum is *"not engaging, low mood, non-compliant to meds, doesn't talk about her issues."* Worryingly, **[I/S]** (Ward Manager) records that the *"legal team has apparently advised the social care team not to get involved as it is a family issue."* This was clearly not the case, as social services remained involved with mum and her family up until her death. While it is correct that there was no restraining order in place, there was a red flag protection in place for dad with Essex Police, as previously detailed and initiated by social services.

231. The ward review also records that **social services** *called 18/2 saying safeguarding was raised and if Dorothy entered the premises, she is at risk of arrest."*

However, it appears the police had not confirmed or clarified the type of safeguarding in place to the ward at the time of their inquiry.

232. From the content of the ward review, it is clear the ward was making active attempts to facilitate mum's discharge home without safeguarding being completed. The EPUT safeguarding investigation remained open until mum's death. Social Services and Community Mental Health were neither made aware of, nor allowed input into, this discharge, and no support was offered or in place for mum. Furthermore, the discharge plan was not reviewed, as recommended, following the earlier self-discharge incident on 20th February 2021, resulting in a repeat of the same unsafe scenario.

233. On 3rd March 2021, it is recorded in the medical records at page37, by [I/S] [I/S] (HCP Nurse) that Mum was insistent on going home, and the ward was actively facilitating this, despite the clear risks involved. It is noted: *"management advised to close safeguarding as soon as possible."* This seems ambiguous, as safeguarding investigations were still ongoing and no support services were in place.

234. The medical records state that mum made three phone calls to family members, including dad. In reality, she made over 14 calls and voicemails between 14:30 and 18:41, details of which are included in dad's draft witness statement for Birketts LLP. Contrary to the records, dad did answer briefly but found it impossible to reason with mum and ended the call. My sister also accepted a call again, not as recorded (it did not go to voicemail), during which mum briefly stated she was safe and on the ward.

235. Both of mum's grandsons received missed calls and voicemails but were at work and unable to answer. One grandson later called the ward and spoke to **the ward manager** inquiring why the ward was allowing discharge without safeguarding or support in place, why they were frightening dad and making him cry, and why the family was being bombarded with calls. **He** abruptly ended the call, clearly unwilling to explain the ward's actions. It became evident that the ward staff were enabling the calls as mum did not have a mobile phone. **The HCP nurse** page 37, records that the many calls were made using the ward office phone.

236. On 4th March 2021 at page 35 of mum's medical records, includes an email sent at noon from [I/S] (Senior Social Work Practitioner Mental Health)

to [I/S] (RMN), raising concerns about care and safeguarding around the imminent discharge. He highlights a problem regarding who is responsible for arranging accommodation. He also notes that several documents are missing from PARIS, specifically the Care Needs Assessment (under the Care Act 2014) and the Occupational Therapy assessment.

237. At 12:06 on the same day at page 33 of mum's medical records, [I/S] (Care Coordinator, CPN) records that the family had been contacted by the ward; we were not. He also falsely records a reaction from me, stating *"family dynamic going on already."* Alarmingly, the notes also state: *"we as a team are supporting her by making the transition easy for her,"* despite the absence of any actual support or safeguarding resolution. The CC's record acknowledges key risks including suicidal ideation, falls, safeguarding concerns and states: *"need to be raised by ward,"* with further concerns about *"house finances and belongings."* None of these issues were addressed by the ward, and yet discharge was still being pursued.

238. At 12:20 on the same day, at page 32 of mum's medical records, [I/S] (HCP Nurse) records a discussion with RMN to confirm *"Home First involvement in Dorothy's discharge plan."* No accommodation plan is in place, and community support appears to consist only of a check by the community care coordinator within 48 hours, and a seven-day follow-up, a plan seemingly recommended by Ruby Ward.

239. Later that evening as noted at page 31 of mum's medical records, [I/S] [I/S] records that mum is *"known to mental health services,"* had an *"intentional mixed overdose,"* has *"manic depression,"* and that *"Dorothy hit her husband with a remote control and locked him out of the house."* These are facts that Dr B had repeatedly denied to the family over many weeks. The diagnosis is still recorded as Manic Depression, not BPD as Dr B had told mum's family. A plan to allow self-discharge against medical advice seems to have been agreed following the ward round the day before. It is noted that mum is vulnerable and may not be able to access her home due to the ongoing safeguarding investigation and red flag alert issued by police.

240. Despite this, the ward accepts mum's unsatisfactory claim that *"neighbours will support her",* which was not the case. Essex Police appear to have been notified of Mum's self-discharge (Officer [I/S] Collar No. [I/S]. An Essex Police Mental Health Street Triage Screening Form (time-stamped 14:10) was

completed and is available. This form lists mum's diagnosis as *"Manic Depression,"* not BPD. Although it is recorded that family members were called and did not answer, no family member received a call to inform us of mum's self-discharge.

Transfer

241. As noted above, mum was initially admitted to Heybridge Ward after attending A&E on 18th January 2021, where she remained for two days. She was then moved to Ruby Ward on 20th January 2021.

Discharge and Continuity of Care and Treatment in the Community

242. Please refer to the section above regarding self-discharge. Mum self-discharged as previously outlined.

Police Incident – 4th March 2021

243. On 4th March 2021, at approximately 3:25pm, mum arrived by taxi at the home she previously shared with Dad prior to her admission. The taxi driver unloaded her belongings. According to the PSI investigation and the medical records, mum was accompanied by someone from the ward, but that individual did not exit the taxi to ensure mum had access to her home, a failing explicitly identified in the PSI investigation.

244. Mum knocked on the window to ask dad to let her in. As advised by police and in accordance with the red flag alert on his number, dad refused entry and immediately contacted the police. They arrived with blue lights as arranged.

245. Dad called me to explain that mum had been discharged and was trying to enter the home. I arrived around half an hour later to support dad and speak with the attending officers. Two female officers listened to our account of events and reassured us that mum would not be allowed into the property due to an active safeguarding issue. They advised us to contact social services to verify whether accommodation for mum had been arranged.

246. The duty social worker confirmed there was no accommodation arranged and expressed alarm that Ruby Ward had discharged mum without their knowledge. Mum

was being looked after at a neighbour's house at that point. Essex Police Street Triage officers were also in attendance and determined they would locate emergency overnight accommodation for mum and contact social services for further steps. As mum had no money, dad gave the police funds to cover her accommodation and subsistence.

5th March 2021 – Aftermath and safeguarding failures

247. The following morning, we contacted social services due to growing concern for mum's wellbeing. The exact scenario we had sought to avoid and most feared, had now occurred. Social services were equally alarmed and confused by Ruby Ward's actions in allowing a self-discharge into an unsupported situation.

248. Social services collected mum from her overnight accommodation and arranged temporary housing at the Chelmer Hotel, Chelmsford, facilitated by Chelmsford City Council.

249. Mum's medical records dated 5th March 2021 at pages 29-30, indicate that [I/S] (Ward Manager) notified [I/S] (Senior Social Work Practitioner) that mum was not at home, was in temporary accommodation, and that social care had been informed. [I/S] (Ruby Ward, CHP Nurse) was unable to conduct the required 24-hour follow-up call because mum had no mobile phone. Housing Officer [I/S] also struggled to contact mum and her family. I eventually spoke with him, but at this point, communication was difficult. [I/S] later wrote to [I/S] stating that mum had *"kicked off a bit"* at the hotel.

250. [I/S] mum's community care coordinator, also failed to reach her and planned to visit on Monday 8th March 2021, four days after discharge. No coordinated care was in place. All necessary support services were disjointed, leaving mum vulnerable. Social services kept us informed, but the family was extremely worried about mum's increasing risk of relapse and overall fragile state.

6th March 2021 – Arrangements for mum

251. On 6th March 2021, I met with mum's social worker, [I/S] to organise the handover of mum's belongings and money provided by dad for her subsistence. We were advised that mum was very irritable and hostile, and the social

worker felt it unwise for the family to approach her directly, fearing it might trigger further aggression or hostility.

9th March 2021 - Second overdose

252. In the afternoon of 9th March 2021, I received a phone call from [I/S] mum's social worker, informing me that mum had told her care coordinator, [I/S] [I/S] that she had overdosed, prompting him to call an ambulance.

253. That evening, I received a call from A&E at Broomfield Hospital, seeking background information. I pleaded with the doctor to ensure mum received proper treatment. I was reassured that mental health services would be contacted for an assessment, and that I would be informed of the outcome.

254. On 9th March 2021, according to [I/S] (HCP Nurse) at page 28 of mum's medical records, her diagnosis is listed as personality disorder, not manic depression, continuing the ongoing diagnostic confusion. There also appears to be a discrepancy in the number of tablets taken. Mum's recorded weight loss and general decline were deeply distressing.

255. On 10th March 2021, after receiving no updates overnight from A&E or mental health, I called Broomfield Hospital, only to learn that mum had been discharged around 11pm the previous night via taxi, back to her temporary accommodation. I immediately contacted social services, who were also unaware of the discharge and began making inquiries.

Post-overdose record and lack of support

256. On 9th March 201, the CC recorded at 16:44 on page 22 of mum's medical records that he had failed to carry out the planned visit on 8th March, and that the last contact mum had with services was on 6th March. None of the planned 24hr and 48hr post-discharge checks by Ruby Ward or community mental health professionals had occurred.

257. During the delayed visit on 9th March, mum disclosed the overdose. The CC attempted to establish what medication and quantity had been taken, but the empty packets presented suggested mum had taken more than she was disclosing.

258. An incident report (Ref: E181330) was logged, and emails were sent to multiple clinicians and health professionals (page. 21, 9th March).

10th–12th March 2021 – Ongoing risk and poor coordination

259. 10th March (10:16): [I/S] (HCP Nurse) records that the MDT discussed mum, with concerns regarding diagnosis, isolation, and overdose risk. Mum's diagnosis is listed as Bipolar by Dr. A An urgent face-to-face consultation was requested; Dr [I/S] was to contact mum. The nurse could only message, with no direct contact made.

260. 10:28: [I/S] (HCP Nurse) records a call with the CC confirming his visit and referral to Gatekeeping. He had also received the RAID Team's concerns. A missing V3 form (not specified) was preventing completion of the Gatekeeping assessment.

261. 13:46: A redacted email to the CC appears to confirm the diagnosis of Bipolar, with possible discharge decision made by Dr. [I/S] after A&E admission. Concerns about mum's lack of a working mobile phone persist.

262. 14:40: HCP nurse at page 18 of mum's medical records, records that a duty worker, [I/S] and a colleague visited mum. They reported that mum denied suicidal intent, and their account seems to dismiss risk, though later updates from the CC contradict this.

263. Despite being given a phone (courtesy of social services), mum struggled to operate it, rendering most safety plans ineffective.

264. 11th March: At an MDT zoning meeting, mum's risk level was rated RED – Inpatient (meaning in crisis). the CC notes following his 10th March visit confirm: mum was tearful, low in mood, expressed intrusive thoughts, and denied plans of suicide but was clearly vulnerable. Diagnosis recorded as BPD.

Legal and social developments

265. The social worker contacts the family to say it is evident Mum needs far more support than initially thought. She suggests supported mental health housing, although options are limited for someone of mum's age.

266. The CC contacts mum on 11th March, again having to call the hotel as she still couldn't answer her phone. He gives her a crisis line, despite her being unable to use her mobile phone.

267. On 12th March, the CC visits mum as noted on page 15 of her medical records. She is told that she has been referred to Home First. Alarmingly, mum refuses visits from the Home Treatment Team or Gatekeeping, denies suicidal ideation, and no acute risk is recorded. The Gatekeeping assessment is withdrawn, and mum appears to be withdrawing from support.

Legal Action and Final Arrangements

268. Social services arranges a meeting between mum and my nephew (her grandson) for 16th March, hoping to re-establish family contact.

269. Dad informs social services that he has instructed a solicitor regarding the legalities of mum's ongoing care, division of joint funds, and his safety. Social services are helping mum open a bank account in her name to facilitate the transfer.

270. On 8th March, mum withdrew £500 from the joint account for her subsistence.

271. On 15th March, dad made the painful decision to proceed with a non-molestation order and divorce, with court documents prepared that day. He withdrew exactly half the funds from the joint account and opened a new one in his name, transferring his pension and bill payments to it, in accordance with solicitor and social services advice at the bank. However, the funds that were meant to be transferred to mum, never actually happened. But this was on the day the coroner believed mum had died.

272. As services, clinicians and staff continued to fail to act to protect mum giving lip service to the dangers and risks an argument ensued between them regarding who should have done what and when. However, it was too late though as mum was likely already dead.

273. The coroner placed an approximate time of death of mum, being between 15th and 16th March 2021.

274. The police incident on 13th March 2021, had left dad with only the clothes he stood in, mum's hostility, aggression and violence meant it was not safe to approach mum to get dad's belongings. So, Essex police arranged that my husband would accompany an officer [I/S] into the property on Tuesday 16th March 2021, to collect them.

275. Police could not get a reply at the door, so called for backup, other officers forced the door open and again smashed through the bathroom door to find mum dead. My husband had the indignity of having to be questioned by police at the scene, having to remain there for some hours until they felt sure he was not involved, he later had to identify mum too, all very harrowing and so upsetting that he broke down in tears after.

Engagement

Patient Safety Investigations

276. Two patient safety investigations were carried out by EPUT following mum's death. These are as follows:

1. Complaint No. 29363

Trust Identifier: PSII E181790
STEIS: 2021/6704

277. This complaint was initiated on 16th February 2021 (see email dated 16th February 2021) via PALS. Correspondence and phone calls followed with various staff members including [I/S] in the Complaints Department at The Lodge, Runwell. This was while mum was still on Ruby Ward and continued after her discharge on 4th March 2021.

278. On 10th March 2021, following mum's second overdose the day before and another unsafe discharge from A&E, mum's family provided a detailed list of our issues and concerns for both mum's and dad's safety. This prompted the complaints department to offer a meeting with [I/S] (Clinical Director of Older Adults, The Crystal Centre). It was to be a conference call at 2 pm on 16th March 2021. However, this never took place, as mum had been found dead by this time.

279. This complaint and all reference numbers were converted into a Patient Safety Investigation (PSI) following mum's death. The family was appointed a Family Liaison Officer, [I/S] (Nurse in Charge, Willow Ward, Rochford). We were also contacted by the Patient Safety Incident Management Team ([I/S], [I/S]), who provided details of the PSI procedures and duty of candour on 12th April 2021.

280. A video call was held with mum's family, [I/S] (Lead Investigator), and [I/S] (Clinical Lead, Geriatric Care). Two other members of the team, Dr. [I/S] (Medical Input) and [I/S] (Safeguarding Input), were unavailable. We later found out from mum's medical records that [I/S] had been part of the safeguarding team responsible for investigating after mum's admission to Ruby Ward.

281. This investigation, recorded in the medical records, was still outstanding at the time of mum's death. Upon learning this, we approached the Investigating Team. **The Lead Investigator** apologised and confirmed he should have checked, and that **safeguarding input** should have disclosed her involvement in mum's care. We were also told that due to staff shortages in safeguarding roles, it would have been difficult to find another qualified person. In mum's family's opinion, this severely compromised the PSI.

282. Following this meeting, mum's family provided numerous documents from mum's GP, as well as a detailed list of the issues we wanted addressed.

283. I was offered the opportunity to request mum's medical records, covering the period from her admission to A&E on 18th January 2021 to 16th March 2021, when she was found deceased. These records were released to me on 9th July 2021.

284. After reviewing 150 pages of medical records, I emailed our Family Liaison Officer [I/S] [I/S] (Lead PSI Investigator), and [I/S] (Investigating Team), raising several concerns that needed to be investigated. I received no reply. I sent a reminder on 1st September 2021, and after still receiving no response, I called **FLO** on 7th September. She informed me the investigation was complete and awaiting approval by the executive team, and that I would receive a copy by email. **FLO** hen suggested a meeting to discuss the family's concerns, indicating that the investigation would need to be reopened in light of the medical records.

285. I received the PSI report on 7th October 2021. mum's family learned that the investigation had concluded on 28th July 2021. We were not given the opportunity to view and provide input on the draft report, despite the clear guidance in the Information for Families Following Bereavement booklet, which states families should comment on the draft report before it is signed off and that their comments should be incorporated.

286. We discovered that mum's family was the last to see the report, it had already been distributed across EPUT. We were denied access to the report for six weeks, and no explanation has ever been given for either the delay or failure to share the draft with us.

287. On 11th November 2021, having heard nothing further regarding a meeting to discuss our concerns, I phoned **FLO** She tentatively proposed a meeting with the Investigating Team for 2nd December 2021 but said she would confirm. **[I/S]** from the EPUT Complaints Department informed me that such a meeting could not include discussion of our further concerns and would be limited to the report itself.

288. Having received no confirmation of the 2nd December meeting, I emailed **FLO** on 25th November. She was unable to assist, so I contacted **the investigators and the FLO** again on 30th November.

289. A meeting took place on 2nd December 2021 **with investigators [I/S]** The outcome of this meeting is recorded by the family in a document titled EPUT PSI – Our Conclusions, Further Issues Not Covered or Fully Explored.

290. On 8th December 2021, I received an email from Paul Scott (Chief Executive, EPUT Complaints Department, Runwell), stating that EPUT considered all matters raised to be addressed in the PSI. He suggested that if we were dissatisfied, we should approach the Parliamentary and Health Service Ombudsman.

291. On 12th December 2021, I supplied the Complaints Department with a list of further issues needing answers, within the four-week timeframe they had confirmed.

292. On 13th December 2021, I contacted the Parliamentary and Health Service Ombudsman for advice. They recommended I complete their complaint form and submit supporting evidence, which submitted on 4th January 2022 by post.

293. On 3rd February 2022, they advised that EPUT must respond to our further questions before they could intervene. If EPUT refused, the Ombudsman said they would step in.

294. Despite lacking confidence in EPUT's willingness or ability to investigate further, we had no choice.

295. On 8th February 2022, a further complaint was initiated with EPUT.

2. Complaint Ref: 31202

296. This complaint was opened on 8th February 2022, following my list of concerns submitted to EPUT on 3rd February.

297. On 28th March 2022, I received an email from [I/S] [I/S] (Consultant Psychiatrist and Clinical Director, Mid & West Essex), proposing a face-to-face meeting to discuss the complaint.

298. By 6th May 2022, I had not been contacted by his secretary, so I emailed Dr. [I/S] directly. A meeting was eventually arranged for 19th May 2022, attended by myself, dad, and my sister at dad's home. Dr. [I/S] introduced himself as both a clinician and a lawyer and assured us he would conduct a legal-style investigation, using only corroborated evidence. (Notes of this meeting are available.)

299. Parts of the meeting were heated, especially regarding suicide risk. Clinicians had previously stated they did not view attempted suicide as evidence of future risk unless it resulted in serious injury, a position reiterated in the complaint report.

300. On 2nd August 2022, we received an email from [I/S] (Complaints Department) confirming Dr. [I/S] had completed his investigation and that the report was expected by 7th September 2022.

301. On 20th September 2022, Dr. [I/S] report was released to mum's family (copy and detailed family response available). Despite assurances, he did not rely solely on corroborated evidence. The tone of the family's response reflected our frustration at yet another failure by EPUT to provide meaningful answers. We were exasperated and

declined further engagement. While we could have pursued the matter with the Parliamentary and Health Ombudsman, mum's family was emotionally exhausted.

302. As the family spokesperson, I could not continue. My husband had a critically ill family member in Australia, and within six weeks we had travelled there to be with them in their final days, attend the funeral, and return home in the new year. Upon our return, dad was hospitalised with respiratory issues following a virus (he has COPD).

Correspondence with Rt Hon John Whittingdale

303. Following mum's unsafe discharge on 4th March 2021, my sister emailed John Whittingdale MP (MP for mum and dad's constituency). (Email thread from 4th March to 19th May 2021 available.)

304. On 11th March 2021, the MP asked if we would like him to request an urgent Mental Health Act assessment for mum, stating: *"given that your mother's safety and the safety of others is at risk."*

305. On 15th March 2021, he confirmed he had written to the complaints department on our behalf and offered support for an assessment.

306. On 23rd March 2021, my sister emailed to inform him that Mum had died, possibly by suicide.

307. John Whittingdale MP continued to liaise with PALS and became aware of Essex Police's handling of the 13th March 2021 incident. He contacted Police, Fire and Crime Commissioner [I/S] on our behalf. The IOPC eventually took up the investigation into Essex Police, but due to an error, our complaint had been referred to PFCC instead of directly to the IOPC, causing significant delays. Once this was resolved, contact with John Whittingdale ceased, as there seemed little more he could do.

Healthwatch

Healthwatch was contacted but could only offer advocacy. We did not pursue this further.

Concerns and complaints: the quality, timeliness, openness, and adequacy of responses to concerns

13th March 2021 - Police incident

308. This was a long, protracted, terrifying, and traumatic incident which lasted approximately four hours, exasperated by Essex Police's poor handling of a sensitive and complex situation. There were two complaints made with the IOPC regarding unlawful arrests made.

309. Despite initial support, after two reviews the IOPC made the decision to drop our case (see right of review letter 13th July 2023, setting out the issues unresolved by Essex Police's investigations).

310. An attempt to sue Essex Police based on these issues, requesting an out-of-court settlement, followed; they refused to accept liability. The only option open at this point is to sue in open court, which will be prohibitively expensive. (The document headed The Second Police Complaint gives a detailed description of the events and the basis of the two complaints that were dealt with by the IOPC).

311. To conclude, dad was arrested along with me, evidentially and unlawfully, to allow mum access to the home they shared prior to her admission to Ruby Ward on 18th Jan 2021. Dad was now staying with me. We are all, as a family, trying to process what has happened; we are all shocked and traumatised.

312. We are still greatly concerned that mum is alone in the house and wonder if social services and community mental health have been made aware of what has happened. I rang **[I/S]** (social services) first thing Monday morning, 15th March 2021; she was again shocked they had not been told by police about the incident on 13th March 2021, and social services agreed to investigate.

313. On 15th March 2021 (medical records, page. 8), **[I/S]** (social services) email to **[I/S]** (ward manager) and **[I/S]** (matron) Ruby Ward is

recorded. SS requests an *"urgent update on* Dad's *safeguarding inquiry."* She confirms that a *"serious incident has occurred over the weekend,"* and she is seeking information from the police.

314. [I/S] (ward manager) confirms *"safeguarding remains open."* He confirms he had contacted the safeguarding team [I/S] for advice on closing the safeguarding. Safeguarding was interested in knowing DR's whereabouts, measures in place to protect her, as well as what's in place to protect Dad at home. He seemed to have no answers to these questions and passed the responsibility to the care coordinator [I/S], who was not able to *"provide robust information."*

315. A meeting is referred to for 16th March 2021. This is all very alarming, as Ruby Ward allowed discharge without any safeguarding in place at all, something the family suspected they would do, without any consideration of the risks that were clear to mum's family. It is becoming evident that there was never any intent to give mum a safe discharge.

316. The remaining pages of the medical records from 15th March 21 (pages 2 to 8) are an email thread between [I/S] (senior social work practitioner, mental health), [I/S] (social services), and [I/S] (ward manager, Ruby Ward). SS confirms to ward that DATIX E181330 has been recorded (this appears to have been triggered following mum's overdose on 9th March 2021).

317. He indicates the *"possibility of inappropriate discharge,"* following the fact that a Ruby Ward staff member recorded *"advise go down the care co route for safe discharge and arrange accommodation"* (this was recorded by [I/S] 3rd March 2021, page. 37 of medical records), which seems to be an inappropriate recommendation and reason for the discharge.

318. Social services goes on to say, *"in the particular situation, it was not a care co responsibility to arrange a safe discharge and arrange accommodation." "There was no discharge planning, and ward staff seems did not follow their duties to make 'duty to refer' referral to the local authority."*

319. He also points out that ward staff did not inform the older adults social care team on the day of discharge, so were unable to fulfil their duties, including wellbeing.

Finally, he says, *"the situation has caused significant distress to the professionals involved and services involved"* (I might add to this that these clear failings have caused mum and her family significant distress and trauma too).

320. The details of DATIX are also confirmed here. **SS** points out to **ward** that safeguarding was raised on mum's admission to Ruby Ward and related to domestic abuse. **Ward** goes on the defensive: *"be advised that this was not a question of safe or inappropriate discharge."* He still does not understand the risk he took in allowing self-discharge into such an unsupported environment for Mum. This just defies logic.

321. He refers to the MHA and how this could not be used, but at least three clinicians within the records recommend its use to avoid an unsafe discharge. **Senior social worker** reply to this is clear and concise and gives comprehensive evidence that mum's discharge was unsafe and protocols were not followed, so they are reproduced here.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

Care Quality Commission

322. The CQC were approached in a telephone call; a complaint was registered, but no feedback or information was ever received from them following our complaint.

Other investigations or legal proceedings

323. See the above safety investigations under engagement.

My Views / After Mum's Death

Conclusions

324. I write *"conclusion"* as a heading but know there has not and will not be a conclusion to the tragedy of mum's end of life and the harrowing trauma both mum and her family have suffered, and her family will continue to suffer.

325. I write this on the fourth anniversary of mum being found dead. Perhaps I should not on this day, it is too triggering emotionally and psychologically but every

day or any day what we have all experienced as a family is triggering. Thoughts intrude at any hour of the day or night and have to be dealt with somehow, or one cannot function.

326. I have, to a degree and with help, developed these tools, but they do not change the fundamental trauma suffered and what it does to you. For me and my family, this will be an unending issue for all of us, to have to find a way through somehow.

327. I continue to write this as my voice and truth need desperately to be recognised and heard, and hopefully something done to stop what happened to Mum and her family happening to others. That is my unending duty to mum's memory, to carry on with our truth, THE TRUTH, and make sure everyone knows it.

328. The inquiry requests details of mum's death and its impact and how things could have been done differently. What I have recorded so far in the lead-up to mum's death is a catastrophic, unending series of scenarios that led to mum's death. This is corroborated in much of the evidence I have supplied and in mum's medical records. To just name a few issues: diagnosis, treatment, discharge, care and risk, safeguarding, communication between services and family, record keeping and its accuracy, etc. The list of failings is just too long.

329. A family expects that their elderly loved one at death is supported, cared for, their pain relieved, and that family and friends are present to say goodbyes and supported too, in an environment of care and support. Mum and her family were denied this. Mum was undeniably suffering a severe mental health crisis that was seriously threatening her life and, sadly, that of others too, but nothing was done to treat her, support her, or her family.

330. Compared with life-threatening physical illness, where treatment, support, and care are available in an environment suitable for their needs and mental health appears to be treated in a totally different way, which fails to provide care, support, and treatment to the most vulnerable and at-risk patients in an environment suitable for their needs. The question must be asked, WHY?

331. The day after the police incident of 13th March 2021, mum was alone in the property and neighbours contacted us to confirm that mum was wandering about,

ringing on neighbours' doors asking for food and to make telephone calls. We reassured them that there was ample food in the property and the phone was working the day previously, but that mum often pulled out the phone lines.

332. Neighbours told us they were reluctant to offer mum entry to their homes due to mum's unpredictable behaviours and the fact that two neighbours had already endured police having to enter their homes when they had allowed mum entry, and they were understandably reluctant to do so again.

333. We assured them that we would be in contact with social services immediately on Monday morning to make sure they could keep mum safe and knew where she was, etc. The neighbours managed to persuade mum to go home.

334. On 16th March 2021, as described before, my husband accompanied a police officer to the property mum and dad shared, to collect dad's clothes and belongings, where three days previously (13th March 2021 police incident) police had unlawfully engineered the removal of dad to allow mum into the property, failing catastrophically to make sure Mum was safe in this environment and services knew of her whereabouts. Mum did not answer the door; police forced the door and broke down the bathroom door to find mum dead there.

335. As described before, my husband endured questioning at the scene and was not allowed to leave for a couple of hours as police eliminated him as a suspect. During this time, mum's care coordinator (**[I/S]**) arrived telling my husband he had not known where mum was and had been trying to ring her to no avail.

336. My husband was terribly shocked and upset by his reaction at being told by police that mum was dead. He broke down physically and emotionally, having to be supported by my husband until a colleague of his arrived to offer him support.

337. We were told by PC **[I/S]** later that evening, when he returned the house keys to us, that they had done their best to clean up the bathroom, but a week later when the family entered the property, this was not the case.

338. My husband, brother-in-law, and my son bravely cleared and cleaned the bathroom, not wanting me, my sister, and dad to see the awful scene. This is my

husband's description of what he found and had to do, which he told me some months after when I felt able to ask:

339. The bathroom door was still on its hinges but was completely smashed, police having to do this to gain entry as the door was locked. The bathroom was in complete disarray; wet blood-stained towels were strewn across the floor, the window blind was ripped from the wall and was in the bath in a residual amount of blood-stained water. Among the towels, several sharp blood-stained knives were found, and blood stains were splattered around the bathroom.

340. My son sometime later told me how shocking it had been for him and how surprised he was that family were expected to clear and clean up after this type of death. He is right: family must be offered support following this type of death and I would suggest that the inquiry investigates this.

341. The coroner at autopsy could not find evidence that the self-harm that mum had inflicted on herself in the short time before her death had caused her death; also, no other underlying health issues could explain her death either; hence her death was recorded as *"old age."* There was a discussion with the coroner's assistant [I/S] [I/S] about mum's mental distress and how this could impact her physically. He said that we have little to go on in these cases; the human body is complex, and any mental distress does have an impact, but for the purposes of cause of death, we must look for physical evidence. Dad said to me after mum's death that he believed *"mum could not go on and the angels just took her away to somewhere better."*

342. Among the things found in the property were many notes on scraps of paper, envelopes, and notebooks. Some were taken by police and later returned to the family. These make distressing reading. They range from accusatory tirades against family members, the same details written down time and again, details of childhood events and trauma, some notes whilst mum was on Ruby Ward. Much of these notes refer to mum's complaints about many things, including her medication and having to stay on the ward, details of her funeral wishes and where she wanted her ashes scattered, poetry, and sayings too.

343. As was the case all her life during mum's episodes of most struggle, she always appeared to be trying to find answers. Surrounding the attack on dad, mum writes, *"I*

did not hit my husband at any time" and *"I swear remembering him saying on the night of the alleged he felt something holding his head."*

344. It is mum's family's strongly held belief that mum was deeply ashamed of her often-hostile actions and reactions towards her family, disassociating herself from it and denying it as her way of coping with it. This caused the rifts in her relationships; she struggled reconciling her open hostility towards her family at times and her need to love them and be loved and supported by them.

345. Dad passed away in February 2024. He spent three months in Broomfield Hospital, initially admitted for a sudden and complete loss of mobility. Despite specifically telling ward staff as we left dad on the first day that he might try to get out of bed and not realise he could no longer stand and walk, staff were not aware and did not seem interested. Still in an A&E trolley, he fell from the trolley in the early hours of the morning less than 24 hours after admission, breaking his hip, and went on to have a very severe heart attack, very probably caused by the shock. It was not thought he would make it through the night.

346. Again, our family were amid DATIX and patient safety investigations. This was just too much for us all and we refused to engage with EPUT's processes, and we do not have any idea what the outcome was. Essentially, dad miraculously rallied but never recovered. He battled on, not really recovering from a bout of COVID caught on the ward. In his memory, I must pursue truth and justice for the way he was treated too; his trauma and distress must not be treated with the contempt that Ruby Ward and Essex Police afforded it.

347. Later, Essex Police also attacked mum's family openly in investigations and reports, despite this being against the *"Statutory Guidance on the Police Complaints System"* and despite the IOPC reminding them not to continue to do this, but they persisted. The PSI and the complaint investigation carried out by Dr [I/S] and Essex Police all made unfounded accusations about.

348. Mum's family without any corroborative evidence to back their accusations up. This, we feel, primarily was used to attack mum's family when we were at our most vulnerable, to distract from their own shortcomings and catastrophic decisions that they chose not to admit, in the hope we would go away. This shows the ability for our

public service professionals and services to show a complete lack of integrity, obstructing getting to the truth.

349. Getting to the truth is seriously hampered by the fact that all these services investigate themselves; this is particularly relevant to EPUT and Essex Police's investigations. The IOPC also appears to be a wholly impotent organisation that will support you, pointing out the police's failings, then make a baffling decision to suddenly close any further investigation.

350. I appeal to the inquiry to stop this serious and damaging obstruction. Investigations must be independent, strictly regulated, and any service that flouts the rules for investigation and covers up wrongdoing needs to be exposed and robustly dealt with.

351. The patient must always be central to care and risk management, with input and proper recorded evidence to routinely include that from family, carers, and friends. Shortcuts to suit the clinicians and services should not take precedence over patient care. Investigations must be patient centred too; they must only use corroborated evidence.

352. Where gaps in service and care are evident (we learn from mum's PSI that the discharge coordinator's job was vacant on Ruby Ward at the time, with no cover or plan in place until the position was filled), these errors must be exposed. The priority that we see now, to protect individual staff or the services as a whole at the expense of the truth, must cease.

353. The failure of all the investigation systems to concentrate on culpability of individuals and services misses the point of trying to prevent the same scenarios playing out time and again. The emphasis is placed wrongly on investigating systems and learning. Our experience is that learning is often never implemented or there are huge delays.

354. The emphasis must be on the individual's decisions and how they impacted the patient, why systems and protocols were not adhered to, and how individuals should be retrained and disciplined.

355. In the case of the death of a patient or serious injury suspected, individuals must be prevented from continuing to work with vulnerable individuals until investigation is completed. If it is found that their actions did cause or contribute to a death, their professional bodies must be contacted for action to investigate with a view to striking off and criminal investigation and action taken.

356. All our services must be able to dismiss those that cause harm. We do not expect our healthcare professionals and police to do harm without any consequence, a doctor makes an oath to cause *"no harm,"* and police are expected to protect and serve, so those that do not need to be rooted out. Things need to be much tougher, and the patient and the truth must be the priority always.

357. Much discussion has been made here of mum's struggles that sadly led to her terrible decline and subsequent death, but for much of her life these struggles were episodic, and there were times when Mum appeared content, happy, enjoyed interests and activities, and seemed to cope well.

358. As far as mum's family are concerned, the only reason mum presented to mental health services in her twilight years and not sooner was the devotion of her husband, our dad, who supported her through 64 years of marriage until he could no longer safely do so. At 93, he was given no option legally but to divorce mum, something he did not want to do but he had no option; he had to keep himself safe and provide mum with funds for her ongoing care.

Recommendations for change

359. As a family, we cannot help but feel that with proper assessment, diagnosis, treatment, and support for mum and her family, we could all have been looking at a very different outcome for our mum and dad.

Statement of Truth

I believe that the facts stated in this Rule 9 Witness Statement are true.

Signed: [I/S]

Full Name: JANE D. STANFORD

Dated: 25/6/25

List of Documents

I attach the following list of documents

1. Background information Letter to [I/S] Sutherland Lodge Surgery July 2006, pages from partially complete depression and low mood questionnaire 2006. File containing various outpatients' appointments (referred to Pg. 11&12 witness statement).
2. Medical records 18th Jan 21 to 16th March 21, assessments, drugs charts etc.
3. Documents supplied by mums GP: letter faxed to GP on 27th Dec 20. Email to GP 4th Jan 21, GP's assessment to Dr [A] 6th Jan 21.
4. Health in Mind letters dated 18th Jan 21 and 19th Jan 21.
5. Essex police report EP 2021018-0459, regarding police incident 18th Jan 21.
6. Email thread between GP and Access and assessment on 18th Jan 21.
7. Witness statement supplied by dad to Birketts LLP.
8. Letter to mums GP from Dr [A] following her assessment 19th Jan 21.
9. [I/S] 19th Jan 21.
10. Email re PAL's complaint 16th Feb 21.
11. Email to social services re self-discharge 20th Feb 21
12. Essex police Street Triage mental health street screening form.
13. Police incident 13th March 21, document titled Second police complaint, right of review letter dated 13th July 23, copy of. Bank stament confirming mum had funds amounting to £500 for her subsistence.
14. PSI dated 29th July 21,
15. Family conclusions and further concerns after PSI, document named EPUT investigation our conclusion further issues not covered or fully explored.
16. Emails dated 26th July 21 and 1st Sept 21to PSI investigation team following sight of mums' medical records.
17. Letter dated 8th Dec 21 from complaints at The Lodge Runwell following PSI.

18. EPUT patient safety investigation our conclusion further issues not covered and fully explored following meeting with investigation team 2nd Dec 21.
19. Meeting with Dr [I/S] 10am 19th May 22 points that need to be discussed and answered.
20. Complaint 31202 report dated 20th Sept 22.
21. Response to complaint 31202 17th Oct 22.
22. Email thread social services 16th Feb 21 to 17th March 22.
23. Email thread with John Whittingdale MP.