

Tuesday, 10 February 2026

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(2.18 pm)

Private hearing

THE CHAIR: Ms Malhotra.

MS MALHOTRA: Good afternoon, Chair. We are ready to hear from our witness this afternoon. This is a closed, private session. We'll be hearing from [Y15], he would like to be referred to by his first name, he is going to be speaking about [Redacted] David, who is also going to be referred to by his first name.

[Y15] would like to affirm and I will ask if that can be done now, please. Thank you.

WITNESS Y15 (affirmed)

Questioned by MS MALHOTRA

MS MALHOTRA: Thank you very much, [Y15]. Now, you've provided a witness statement and it's dated 1 October 2025. Have you had an opportunity to read it recently?

A. Yes, I've just flipped through it in the room downstairs.

Q. Thank you. Can you confirm that the contents are true and accurate?

A. I can.

Q. Thank you. Now, David, [Redacted], was under the care of SEPT; is that right?

A. Yes.

1 Q. He sadly passed away at Basildon Hospital on 6 February
2 2014. So last Friday marked the 12th anniversary of his
3 death, I believe. He died aged 77 and his death
4 occurred six weeks after he was first sectioned at
5 Meadowview Unit in Grays, Essex. He died, according to
6 his death certificate, from dementia and sepsis. Is
7 that correct?

8 A. That's correct.

9 Q. By way of background, David was first diagnosed with
10 vascular dementia in early 2013; is that your
11 understanding?

12 A. That's to the best of my recollection. We don't have
13 his medical records, so that's working off our memories,
14 yeah.

15 Q. To the best of your recollection, can you appreciating it
was
16 some time ago, can you just describe to us, please, what
17 vascular dementia, what impact that had on him?

18 A. It was mainly linguistic. So it began with him not
19 being able to find a particular word. He'd get to the
20 end of a sentence, he couldn't quite grasp the word.
21 And it sort of gradually got worse, in terms of his --
22 its impact on his ability to communicate. He was still
23 able to converse but he more and more frequently would
24 just not quite be able to find the words he was looking
25 for.

1 And then, right towards the end, it began to -- he
2 began to sundown. So on a handful of occasions, when it
3 got to the evening, he would start to hallucinate, and
4 there were a couple of occasions where he fled the house
5 because he was hallucinating that somebody was chasing
6 him.

7 **Q.** I see. Just explain to us, was that a very regular
8 occurrence or was it quite rare? Could you give
9 a number?

10 **A.** I would say it happened less than five times. It was
11 a handful of times. It may even have been two or three.

12 **Q.** Okay. Two or three occasions when he would flee from
13 the house?

14 **A.** Yes.

15 **Q.** Just explain to us: would he go away for long periods of
16 time or would he come back by himself? Just explain
17 that.

18 **A.** So what he would do: he would run away, he would believe
19 somebody was chasing him. [His wife] was not fast enough
20 to keep up with him, so she would ring the police.

21 I believe on one occasion he went to the police station
22 for help because he believed he was being chased and
23 I think there was another occasion where the police
24 found him. I personally only remember two occasions
25 when it happened but I'm not entirely sure.

1 Q. According to your witness statement -- for those that
2 are following, it's paragraph 12, page 4 -- he was
3 detained on 30 December 2013. I wonder whether -- this
4 was quite an important turning point for David and for
5 you as a family. I would like to just explore a little
6 bit with you how was he in the days leading up to the
7 30 December?

8 A. So I'd seen him at Christmas and he was okay.

9 Q. When you say he was okay, what does that mean to you?

10 A. Oh, he was just his normal self. So, obviously, he was
11 suffering from his speech problems but, otherwise, he
12 was fine. He was, you know, conversing with us all and
13 just enjoying Christmas. I think the day before he was
14 sectioned, the evening before he was sectioned, he had
15 fled the house and we received a telephone call at home
16 the following day from [his wife] to say that there was
17 a social worker at the house and that they were talking
18 about sectioning [David]. So I went to the house [Redacted]
19 and he
20 was -- he was fine when we got there. He wasn't
21 suffering from any hallucinations or delusions or
22 anything like that.

23 But the decision had already been taken by the
24 social worker to call doctors out of the house to look
25 into sectioning him. But on that afternoon, or evening,

1 he was just his normal self.

2 **Q.** Okay, we're going to come back to that in a moment in
3 a little bit more detail. But just in the build-up,
4 help us understand, aside from those instances where
5 David had gone away from the house, was he able to lead
6 a relatively independent life?

7 **A.** Yes, he was, yeah. He would get up every morning, he
8 would go to the newsagent. He would buy a copy of the
9 Daily Mirror. He would bring it home, he would do the
10 crossword.

11 Of a weekend, during the football season, he
12 would -- he was a Leyton Orient season ticket holder --
13 he would get the train from Wickford to London on his
14 own, meet relatives to go to the match, and then come
15 home again on his own. So he was independent, yeah.
16 He -- you know, he was able to live a pretty normal,
17 independent life. The primary symptom was just his
18 speech.

19 **Q.** So you've described for us in outline the 30th and what
20 happened that day. Can you just explain to us: you saw
21 him at Christmas. He was fine, in the sense of he had
22 his usual speech difficulties and challenges but, aside
23 from that, he was fine?

24 **A.** Yes.

25 **Q.** Then we get to the 30th. What had happened the night

1 before that prompted the social worker to attend on the
2 30th?

3 **A.** Obviously, I wasn't present. This would have been
4 reported to us over the phone by [his wife] but he had --
5 he'd had another sundowning incident where he'd believed
6 that someone was chasing him and he'd fled the house.
7 I don't recall on that occasion whether it was that he
8 ran to the police station or the police found him but he
9 was back home that night. He wasn't out overnight or
10 anything.

11 **Q.** You've explained that that night he seemed his normal
12 self once he was back home. Have I understood that
13 correctly?

14 **A.** I wasn't there when he got home that night but I saw him
15 the next afternoon. So we received the call from [his wife]
16 to say the social worker was either there or on her way
17 there and had indicated a desire to have [David]
18 sectioned. So [we] got in the car
19 straightaway and went over there and he was sat in his
20 usual seat in the living room with the TV on, calm and
21 conversational, and just cracking jokes with us, and his
22 usual self.

23 I think we were all worried because of what [his wife]
24 had told us but he seemed all right.

25 **Q.** Just help us understand, please, what prompted the

1 social worker to come and give that indication that they
2 were looking to section him?

3 **A.** I have to assume it was the fact that he'd fled the
4 house the night before because it followed immediately
5 after that happening. So the social worker had been
6 involved, I think, since the previous occasion when he'd
7 fled the house.

8 There was a concern about -- that [his wife] was not --
9 she couldn't lock the doors overnight because it was
10 false imprisonment, so, if he was trying to leave the
11 house, she should not prevent him from doing that. And
12 I think the social worker had been involved for a couple
13 of weeks, maybe.

14 **Q.** I see. So the social worker had been. Appreciating you
15 weren't there at that time, you came afterwards --

16 **A.** Mm-hm.

17 **Q.** -- can you just explain what that interaction ultimately
18 led to and what impact that had on the family?

19 **A.** Yes. So the social worker -- I just don't remember if
20 she was there when we got there but I remember being
21 there with her. I believe doctors had already been
22 called, so we were just sat around waiting for the
23 doctors to arrive in [David's] living room.
24 Eventually, the doctors arrived, so, essentially, the
25 whole decision-making process I was not privy to. It

1 was just that we were informed over the phone that it
2 was happening and we rushed over there but I do
3 remember, when we got there, there was a lot of waiting
4 around, first for the doctors to come and then we were
5 told there was going to be a very protracted wait for an
6 ambulance, which kept getting longer. So, in the end,
7 we had to drive [David] to the facility ourselves, in
8 convoy with the doctors.

9 Q. Okay, so you describe two doctors, they came to the
10 house. You were there when the doctors came?

11 A. I think it was two doctors but, you know, it was a long
12 time ago. It could have been the doctor and the social
13 worker that I remember, but at least one doctor was
14 there, yeah.

15 Q. When you say "doctor", do you know if they were
16 psychiatrists or ...

17 A. I don't know.

18 Q. You don't know. Just up until this point, had [David]
19 harmed himself in any way?

20 A. Not to my knowledge.

21 Q. Had he harmed anybody else?

22 A. Not to my knowledge, no.

23 Q. Aside from fleeing the house at night, was he a danger
24 to himself?

25 A. No, I don't believe so, no. Obviously, the fleeing of

1 the house itself was potentially dangerous, he could
2 have gone into the road or something but, beyond that,
3 I don't believe he was a danger.

4 **Q.** I'm just being asked if I could just ask you to keep your
voice up a little
5 bit?

6 **A.** Sorry.

7 **Q.** **No, no,** you haven't done anything wrong at all but if you
could

8 just keep your voice up a little bit. I think, even
9 though we have the microphones, they don't necessarily
10 amplify. They're there for recording purposes.

11 **A.** Okay.

12 **Q.** So you've described potentially two doctors, one doctor
13 maybe and the social worker. They spoke to David, did
14 they?

15 **A.** Yes. So when they arrived, my recollection is that the
16 entire thing happened extremely quickly. They arrived.
17 I was sat immediately to the left of [David] on the
18 sofa, the doctor who was asking the questions was
19 perched on the arm of the opposite sofa and, from what
20 I can remember, it was -- I would say it took less than
21 two minutes for a decision to be taken to section him.
22 I remember them asking a handful of questions, along the
23 lines of, "What day of the week was it?" You know,
24 could he -- did he know who the Prime Minister was,
25 something along those lines. And then they just said,

1 "Yeah, we're taking him in". So it was a very quick
2 process.

3 Q. Okay, so when you say less than two minutes, was that
4 the entire time that the doctor was there assessing him?

5 A. Yes. So they arrived, introduced themselves, but the
6 actual questioning of [David], if you told me it was
7 less than a minute I wouldn't be surprised. I remember
8 it was extremely quick.

9 Q. So they asked him what day of the week was it and who
10 was the Prime Minister at the time.

11 A. Yeah, things of that nature. They were asking him sort
12 of simple, factual questions.

13 Q. Then, after that, they said they were going to section
14 him?

15 A. Yes.

16 Q. That was under Section 2 of the Mental Health Act; is
17 that your understanding?

18 A. I assume so but I don't know.

19 Q. Okay.

20 A. I don't remember that.

21 Q. Okay.

22 A. They told us that it was about medication. So,
23 essentially, they said they wanted to try different
24 combinations of medication to see if they could find
25 a combination that would stop the sundowning. So they

1 said it would be a section for up to 28 days but
2 probably less while they just tried different
3 medications and, once they'd settled on a formula that
4 was working, he would come home.

5 **Q.** Okay. How did you, as a family, feel about that?

6 **A.** Well, we were not happy about it. Because it was the
7 day before New Year, he was very excited about coming --
8 we were having a New Year's party at our house. He was
9 going to be coming to that party, as he always would.
10 He was looking forward to it. By the time, this was all
11 happening, he seemed to be back to normal. He seemed to
12 be back to his usual self. It was the evening by the
13 time the doctor came. He wasn't sundowning that evening
14 and it was obviously very upsetting to him, as well as
15 all of us.

16 So I remember walking into the hallway -- after the
17 decision had been taken, I remember walking out of the
18 living room and into the hallway of [David's']
19 bungalow and [another family member] was very distraught
and I asked her
20 what had happened, and she said that she had just
21 pleaded with the social worker not to do this, "Please
22 don't do this the day before New Year". And she said
23 that the social worker pulled a face at her and just
24 went, "Mmm, I think I will", like that. And [she] was
25 just so upset. She was absolutely distraught. It was

1 just a horrible, horrible thing for the social worker to
2 do and I don't know why a social worker would behave in
3 that way towards anyone in that circumstance. It was
4 despicable.

5 And that's what I recall. That's -- I remember the
6 doctors being there and I remember that. Those are my
7 prevailing memories from that, you know, period at the
8 house.

9 **Q.** So can you recall whether there was any discussion with
10 the doctor, from the family, saying, "Please don't
11 section him", or was it just to the social worker?

12 **A.** I only recall that discussion with the social worker.
13 I don't recall anyone pleading with the doctor.

14 **Q.** So you told us --

15 **THE CHAIR:** Sorry, was there any discussion about whether or
16 not this treatment that they were suggesting it was for
17 could be managed as an outpatient or --

18 **A.** No.

19 **THE CHAIR:** -- managed in a different way?

20 **A.** No, there wasn't. I mean, obviously, that would have
21 been our preference but nobody was offering that as an
22 option. So the social worker had called the doctor, the
23 doctor arrived, there was a very, very brief questioning
24 of [David] and then they said they were taking him
25 in. So there was no discussion in my presence about

1 doing it as an outpatient.

2 **THE CHAIR:** Just to be clear, no discussion that he could
3 also go as a voluntary patient?

4 **A.** No. No, I'm sure we would have -- if that had been
5 offered as an option, I'm sure that's what we would have
6 done and I don't recall anybody offering that as an
7 option.

8 **THE CHAIR:** And you think he might have gone as voluntary
9 patient, if you'd had that choice?

10 **A.** I do, yes. Yeah, I think so. I mean, he may have
11 changed his mind when he got there and he saw the
12 conditions that he was going to be in at that particular
13 unit but I think that he would have agreed to it up to
14 that point.

15 **THE CHAIR:** Thank you.

16 **MS MALHOTRA:** Thank you.

17 So you described there then being a delay and
18 waiting for an ambulance.

19 **A.** Mm-hm.

20 **Q.** Can you explain to us why an ambulance was necessary?

21 **A.** Well, I believe the doctor called an ambulance, so they
22 wanted -- I don't know. We didn't want an ambulance.
23 That wasn't our suggestion. We were just told that they
24 were calling an ambulance and then it kept getting
25 delayed. I suppose the doctor didn't want to drive him

1 in his own car, maybe.

2 **Q.** So there was a delay waiting for the ambulance and,
3 I think, as a result of the delays, the family then
4 decided to drive David to Meadowview; is that right?

5 **A.** It was getting very late, yeah, and every time somebody
6 rang, I think all the calls were made by the doctor, but
7 every time there was a phone call, they were saying no,
8 it's going to be another two hours, it's going to be
9 another however long. So, in the end, we just
10 volunteered to take [David] there.

11 **Q.** Okay. So just at this time before we do get to
12 Meadowview Unit, explain to us how was David at this
13 particular time?

14 **A.** He was fine. He was placid. He was coherent. He was
15 understanding of the fact that he needed to have his
16 medication checked. I don't think he fully understood
17 that he was being forcibly detained but he was quite
18 willing to go to the hospital and have -- you know, have
19 his medication reviewed and cooperate. He was
20 cooperative. Completely cooperative.

21 **Q.** Then we move to Meadowview Unit. You got there. For
22 those following your statement, if it helps, it's
23 paragraph 30, page 7. You say that you immediately knew
24 it was unsuitable for him, and I just want you to
25 explain, please, why you say that?

1 **A.** When we got there, we were taken into a room that had
2 other patients in it and the patients that were there
3 were all clearly far more unwell than [David]. Many
4 of them, if not all of them, were completely
5 uncommunicative. They were sort of -- there was one
6 that was going around sort of grabbing at people's arms
7 and grabbing at their clothes, and one tried to pick up
8 [David's wife's] handbag, I think, and walk away with it.
They
9 seemed to be people who were in a far more advanced
10 stage of illness than [David] and, immediately,
11 I could see that he was terrified because he didn't feel
12 that he was in a position similar to these patients and,
13 you know, it was frightening. These people were, you
14 know -- unfortunately, were not really in full control
15 of themselves and it was frightening to be around them.

16 And that was not the condition that [David] was
17 in; not even close. So it was -- it didn't seem right.

18 **Q.** When you got there, what were you told about how long
19 David was going to be there?

20 **A.** So when we got there, the story changed. So they had
21 told us it would be a section for up to 28 days but
22 probably less, to review his medication. When we got
23 there, they said it's 28 days at a time. They said, "If
24 we've decided after the first 28 days that it's not
25 working, then it'll be another 28 days and we can keep

1 doing that", which was obviously substantially different
2 to what we'd been told to begin with.

3 **Q.** How did you as a family feel about that?

4 **A.** Well, we were not happy about it. We felt we'd been
5 tricked. We felt we'd been lied to and it was at that
6 point that [David] clocked, because he was uncomfortable
7 with the other patients that were around and the way
8 that they were behaving, and he said, "Actually, I've
9 changed my mind, can we go home?"

10 Then I had to explain to him that he couldn't: he
11 was already detained; the papers had been signed; the
12 decision had been taken. And he -- at that point,
13 everything changed. I mean, he was clearly petrified,
14 and furious, as well. And then everything really sort
15 of got out of control.

16 **Q.** It got out of control how?

17 **A.** Well, he then was not cooperative. So he went from
18 being cooperative to being uncooperative. He was trying to
19 get out of the facility. He was refusing -- they were
20 trying to give him some medication, he wouldn't take it.
21 And then I -- I don't remember why but I ended up on the
22 outside of the unit. [Redacted] but the next thing I
remember is I was

2 stood in the reception area. There was a door with
3 glass windows in the doors, which was a locked door, you
4 couldn't get out of it. And I was stood on the outside
5 and [David] was hammering on the windows, shouting

6 the words -- words to the effect of, "How can you do
7 this? You call yourselves family?"

8 **Q.** What were you, as the family -- are you all right to
9 carry on?

10 **A.** Yeah.

11 **Q.** What were you, as the family, told about visitation?

12 Were you going to be allowed to visit him regularly or
13 were you advised to perhaps not do so?

14 **A.** We were told not to visit. They said that having people
15 visiting from outside would upset him and would sort of
16 remind him of the fact that he was detained. So they
17 told us to stay away and that it was best to leave him
18 in there on his own, which was obviously counter to what
19 we thought would be best for him and we thought that it
20 would only enhance the fact that he thought we'd sort of
21 abandoned him.

22 **Q.** Would you like to take a break?

23 **A.** No, I'm okay.

24 **Q.** I'd like to move on to 4 January. So this would have
25 been 2014. Are you all right to carry on?

1 **A.** Yeah.

2 **Q.** There was a ward visit that day. I don't think you were
3 present on that visit but can you tell us what you
4 learned about it?

5 **A.** I'm sorry. There were two people that visited. So
6 [one family member] went one day and then [others]
7 went another day, so I don't remember
8 which was on the 4th, sorry.

9 **Q.** That's all right. Let's have a look at your statement, that
10 might be able to help us. So if you look at
11 paragraph 42, please, page 11. I'll ask that that's
12 brought up on the screen, as well. Paragraph 42,
13 page 11.

14 **A.** Okay, yes. So it says, "some family members", [redacted].
15 So
16
17 I was not there. But they visited and said that he was
18 much calmer than he had been when they left him days
19 earlier -- or when we left him days earlier. So they
20 said that he basically sat in a chair, I believe, for
21 several hours and was just talking to them.

22 **Q.** You say here at paragraph 42, the final sentence:
23 "[He] was physically well and had no bruising on
24 him."
25 That was on Saturday, 4 January.

1 Then at paragraph 43, we can see there:

2 "Suddenly, the next morning, Sunday, 5 January 2014,
3 [David's wife] received a call to inform her that
4 David had been transferred by ambulance to Basildon
5 Hospital [and that you] found out ... when she'd called
6 to the house and spoke to [a family member]."

7 So just telling us, please, what you learned about
8 that transfer then to Basildon Hospital on 5 January,
9 please.

10 **A.** So I remember [the family member] getting the call but I
didn't

11 immediately go up with her. [Two family members] were the
12 first people to arrive at the hospital and I think [
13 David's wife] followed. So I found out what had happened
14 by telephone call from another family member]. So she told
me that,

15 when she arrived, he was covered in bruises, he had
16 a black eye, and I went up to visit, I think, that
17 evening. I think later that day I went up to visit, so
18 I witnessed his condition myself. It was either that
19 evening or the following evening. I remember being
20 there one evening soon after it happened.

21 **Q.** Just describe to us how he was?

22 **A.** Well, covered in bruises, as I say. Facial bruises,
23 bruises to his arms. I didn't see the rest of his body
24 but other family members did. And he was completely
25 incommunicative. He could not speak at all. And he was

1 shuddering uncontrollably even when he was asleep, he
2 could not stop shuddering, and his arms were shaking,
3 and, even in his sleep, he was just groaning, he was
4 just constantly groaning as if he was in pain or fear,
5 one of the two. So he -- and he never recovered from
6 that.

7 So he remained in that condition for the rest of his
8 life, which was about another six weeks. So he had
9 totally lost the ability to communicate in any way and
10 he was never able to tell us what had happened to him.

11 **Q.** In terms of what happened to him, I'm going to ask that
12 we look, please, at paragraph 46, page 11 of your
13 statement. It's there towards the bottom of the page
14 and it's on the screen in front of you as well, if that
15 helps.

16 But you say here that Meadowview staff were asked
17 about how he had sustained he's injuries and that the
18 accounts kept changing.

19 So here at (a), you say you were initially told that
20 he had fallen out of a chair.

21 **A.** Yeah.

22 **Q.** Then, if we go over the page at (b), the family were
23 told that he had had a seizure; and then at (c),
24 a combination of events: fallen out of the bed and may
25 have suffered a seizure, and then a discussion about

1 there being mattresses on the floor.

2 I wonder if you can help us, please, with, to the
3 best of your recollection, what you were told about how
4 David had received these injuries whilst he was still
5 under section.

6 **A.** He -- well, we were given completely contradictory
7 accounts. So as it says there, initially we were told
8 he had fallen out of a chair. That did not seem to be
9 commensurate with his injuries at all. I mean, he had
10 injuries to his face, his arms, his legs, his back.
11 I think there may even have been bruising on his feet
12 but I can't be 100 per cent about that. But he had
13 bruises all over his body. So I remember when they told
14 [a family member] that he'd fallen out of a chair, she
immediately
15 disbelieved it and said, "Well, how many times did he
16 fall out of the chair?", because, you know, he was
17 covered.

18 At some point the story changed. They started
19 saying fallen out of bed and they started saying he
20 might have had a seizure, which, again, to us, didn't
21 really make any sense because he had never suffered
22 a seizure in his life. He had no history of suffering
23 seizures. Then the story about falling out of bed
24 seemed to be undermined because, at some point, they
25 started telling us that they specifically put a mattress

1 on the floor to stop him getting injured if he fell out
2 of bed.

3 So we, to this day, do not know how he suffered
4 those injuries but we don't really believe any of the
5 explanations that we were given.

6 Q. I'd like to ask you about whether there was an
7 investigation that took place as a result, to try to
8 ascertain how these injuries arose?

9 A. No. So [David's wife] sent a letter to the Meadowview Unit
with

10 some questions in it, which I typed up for her. We went
11 to a meeting at the Meadowview Unit with, I think,
12 a senior sister, her name was [redacted]. In that
13 meeting, we weren't really given any satisfactory
14 explanation.

15 What she offered to do was to read to us all of the
16 observation notes. She didn't give us the observation
17 notes but she offered to read them to us. When she got
18 to the -- there was a certain point. So in this meeting
19 was me, [another family member and David's wife]. And it
got to a certain

20 point in the observation notes and [the other family
member] suddenly

21 realised that these notes were describing the time when
22 [he and others] had actually been
23 there in the unit. And these notes were -- they were
24 all, you know, "At 1.00, David was seen doing this; at
25 2.00, he was seen doing that", and the notes had him in

1 locations that they knew he'd not been in because they
2 were there: they were there with him at these times.

3 So in the middle of the meeting, [the family member]
4 just
5 exclaimed, "Well, hang on a minute, this is all fake.
6 These observation notes are all fake, because we were
7 there".

8 And so the meeting ended with that, really. I don't
9 remember there being any meaningful response from
10 [redacted] to that. I don't remember her saying
11 anything like, "Oh, well, I'll have to investigate that"
12 or "I'll have to look into that".

13 I just remember her sort of brushing it off saying
14 something like, "Oh that's strange", something along
15 those lines, you know.

16 Then we got a letter through the mail saying,
17 "Following our meeting, I'm glad that I was able to
18 answer all your questions and I hope that David gets
19 well again soon", so words to that effect. So no, as
20 far as I'm aware, there was no investigation into either
21 how [David] got injured or how his records came to be
22 falsified.

23 Q. You may or may not be able to answer this but, just in
24 terms of the location where [the other family member] had
25 known David
26 was, do you know where that was, as opposed to what was
27 said in the notes?

1 **A.** I don't. What I remember is that he said that during
2 the visit they stayed in one place for the entire visit.
3 They'd all been sat together for several hours, whereas
4 the notes had him in multiple locations. So he was seen
5 in this room, he was seen in that room and [the family
member] was

6 saying, "Well, that's definitely not right because he
7 didn't move for the duration of our visit".

8 **Q.** The response of the senior member of staff that you
9 spoke to where this discrepancy was highlighted was,
10 "That seems strange", but no indication that that was
11 going to be investigated or followed up, if I've
12 understood your evidence correctly?

13 **A.** Yes, certainly, she might have said words to the effect
14 of, "Oh, I'll have to look into that", but there was
15 definitely no mention of, "There's going to be an
16 investigation", nothing like that, no mention of, you
17 know, "We will launch an investigation", and certainly
18 we never heard anything after that about any
19 investigation.

20 **Q.** Okay. I'd like to ask you, please, then -- I'll
21 actually ask that we put it up on the screen. It's
22 page 14 of your statement, paragraph 51 and 52, please.
23 I'm just going to read those two paragraphs out:

24 "Unfortunately, David was never able to tell us the
25 truth about his injuries and how they occurred. He

1 never regained his ability to communicate after this
2 incident. He became a quivering wreck; he shuddered
3 constantly and made noises as though he was petrified
4 and wounded. Alongside the lack of a clear explanation
5 as to how he sustained such horrendous injuries, there
6 was also no clear explanation as to why he had suddenly
7 and completely lost his ability to speak or properly
8 control his body.

9 "David had been under the care of Meadowview for
10 only six days and, in that time, he had deteriorated to
11 such an extent and at such a pace that nobody [could]
12 believe it unless they saw it themselves. He entered
13 that ward as a happy, independent, communicative man
14 struggling with a few dementia symptoms, and he exited
15 it mere days later as a jabbering, shuddering husk, who
16 never managed to speak a word of sense to any member of
17 his family again. He would sometimes blurt out a word,
18 but with no context or clear intent."

19 I don't wish to dwell or, you know, retraumatise you
20 by going through those facts again but David sadly
21 passed away at Basildon Hospital, as I said at the
22 beginning.

23 Now, there wasn't an inquest into his death, was
24 there?

25 **A.** No. The cause of death that was given by the hospital

1 was a natural cause of death. So his death was
2 attributed to dementia and sepsis. Had I known more
3 about the inquest process at the time, I would have
4 asked for an inquest because he was hospitalised due to
5 those injuries and it's our opinion, as a family, that
6 the injuries directly led to his death because they led
7 to his complete cognitive decline. And the reason --
8 well, certainly one of the reasons he died in the end
9 was because he could no longer eat. He lost the ability
10 to swallow. So he basically shrivelled. He sort of
11 wasted away. And, clearly, the injuries were a factor
12 in his death and I wish that I'd known better at the
13 time because I would have asked for an inquest. I would
14 have pushed for an inquest. But, no, there was not an
15 inquest.

16 **Q.** Now, is there -- I'm going to next turn to
17 recommendations and then you have a commemorative
18 account that you're going to read for us. Before I turn
19 to the recommendations, is there anything that you would
20 like to say that I have not asked you?

21 **A.** I've been told by the legal team that this is not an
22 isolated incident, that there have been other cases
23 where there has been fabrication of records, that there
24 have been other cases of elderly people being taken into
25 the care of the Trust and suffering unexplained

1 injuries.

2 I would like to know more about that. I would like
3 to know if there was a pattern, if there were other
4 people that suffered similar injuries. I would like to
5 know whether the Trust ever did investigate either the
6 cause of [David's] injuries or the fact that we had
7 told them that the records were fabricated. I would
8 like to know, if they did investigate, what the outcomes
9 were; and, if they didn't investigate, I would like to
10 know why they didn't investigate because these are
11 clearly very serious issues. [David] was detained by
12 the state against his will and suffered unexplained and
13 suspicious injuries, and there should have been a proper
14 inquiry at the time.

15 So if the Inquiry is able to look into those
16 matters, then those are matters that we are keen, as
17 a family, are looked into.

18 **Q.** Just before I do move on to your recommendations, in the
19 time that David was there, so from the 30th when he was
20 admitted at Meadowview, until the 4th, and then we know
21 what happened on 5th, with him going to Basildon, was
22 there any update on how his medication had been working
23 or if there was any discussion about how that was
24 progressing?

25 **A.** To the best of my knowledge, there was not. Obviously

1 that update wouldn't have been given to me; it would
2 have been given to [his wife]. My recollection is that
they
3 had instructed us that the best thing we could do is
4 stay away and let them do their job, that it would be
5 counter-productive for us to go and visit him. And
[David's wife
6] was taking that instruction quite seriously, whereas
7 [other family members] were far more skeptical of it and
8 really wanted to go and visit, and [David's wife] kept
saying to
9 them, "Well, they've told us not to".

10 So my recollection, although obviously I can't speak
11 for [David's wife], is that it was basically radio
silence. We
12 didn't hear anything until [a family member] went to visit
and then
13 [other family members] went to visit with
14 .

15 Q. All right, thank you. I wonder if we could have up
16 page 26, paragraph 85, please, of your statement. Here
17 you list your recommendations that you invite the Chair
18 to consider: appropriate risk assessing; assistive
19 technology in older adult patient facilities;
20 post-incident investigations -- and I think if we go
21 over the page you carry on there at (d) -- pattern of
22 neglect with older patients.

23 Is there anything that you would like to expand upon
24 that's not within your witness statement about the

25 recommendations and why you invite the Chair to consider

28

1 those?

2 **A.** So in terms of the assistive technology, we do not know
3 whether [David] actually suffered a fall. That is an
4 explanation that they gave us, that it's not one we
5 necessarily accept and, obviously, the story was
6 changing repeatedly. But, if he suffered a fall, then
7 yes, assistive technology would have been helpful.
8 I don't know if they had it or not. I just don't know.

9 But, no, I think the rest of the recommendations
10 sort of speak for themselves, really. There should have
11 been a post-incident investigation. As far as we're
12 aware, there wasn't. And, hopefully, this Inquiry will
13 get to the bottom of if there was a pattern and, if
14 there was, who was responsible, and how long did it go
15 on for?

16 **MS MALHOTRA:** Thank you very much. I have no further
17 questions for you, those are my questions.

18 Chair, do you have any questions for the witness?

19 **THE CHAIR:** No, I don't, and thank you for your very clear
20 evidence.

21 **THE WITNESS:** Thank you.

22 **MS MALHOTRA:** I think you now have a commemorative account
23 that's in front of you. I think you'd now like to read
24 that commemorative account.

25 **THE WITNESS:** Yes.

1 **MS MALHOTRA:** Just take your time.

2 **Commemorative account of DAVID CANNON (read)**

3 [redacted]

19 **MS MALHOTRA:** Thank you very much, [Y15].

20 I think we've now got two photographs that we're
21 going to see of David. I'll ask if they could be
22 displayed now.

23 *(Photographs displayed)*

24 Thank you very much, [Y15].

25 **THE CHAIR:** I'm extremely grateful for your incredibly

1 moving, commemorative statement and for your evidence.

2 **THE WITNESS:** Thank you.

3 **MS MALHOTRA:** Thank you very much, Chair. That concludes the
4 business today. We resume tomorrow at 10.00 am.

5 **THE CHAIR:** 10.00 am tomorrow. Thank you.

6 **(3.14 pm)**

7 **(The Inquiry adjourned until 10.00 am the following day)**

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I N D E X

WITNESS Y15 (affirmed)1
Questioned by MS MALHOTRA1
Commemorative account of DAVID CANNON (read) .30