

Monday, 9 February 2026

(10.00 am)

THE CHAIR: Good morning, Ms Malhotra.

MS MALHOTRA: Good morning, Chair. Today we return to hearing evidence from the bereaved families of those who died while under the care of trusts in Essex.

This morning we will hear from Samantha Cook. She will be giving evidence about her sister, Paula Parretti, who died on 6 January 2022, aged 46.

Her evidence will be followed by Karen Michel, who will be speaking about her sister, Marion Michel, who died on 4 March 2022, aged 56.

Both sessions will include details of the care and treatment provided to those who died and will also include some detail of how they died. There may be aspects of today's evidence that are difficult to listen to. Understandably, there may be some for whom it may not be possible to sit through the two sessions. As with other days, anyone in the Inquiry room should feel free to leave at any time.

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

1 Q. Have you had an opportunity to read it recently?

2 A. I have, yeah.

3 Q. I think there's a correction you'd like to make, one
4 correction you'd like to make to that statement?

5 A. There is, yes.

6 Q. Perhaps we could have this on the screen. It's page 3,
7 paragraph 13. At paragraph 13, the second sentence:

8 "The wait could then be even longer when staff were
9 not calling or checking in as regularly."

10 I think the correction you'd like to make is the
11 word "staff" should be "family"?

12 A. Yeah.

13 Q. Is that correct?

14 A. Yeah, that's correct.

15 Q. Aside from that correction can you confirm that the
16 contents of your statement are true and accurate?

17 A. I can, yes.

18 Q. Thank you. Now, I've said a few moments ago Paula was
19 your sister --

20 A. Yes.

21 Q. -- and sadly she died by ligature on 6 January 2022,
22 aged only 46. She had a diagnosis of borderline
23 personality disorder in 2024 --

24 A. Yes.

25 Q. -- when she was 29 years old --

1 **A.** *(Witness nodded)*

2 **Q.** -- and a history of addiction and self-harm; is that
3 right?

4 **A.** That's correct, yes.

5 **Q.** I'd like to start at the beginning, if that's all right?

6 **A.** Yes.

7 **Q.** Just in terms of Paula and you, was there a big age
8 difference between the two of you?

9 **A.** There was, there was a nine-year age gap.

10 **Q.** So would it be fair to say that, speaking about the
11 earlier events of her life might be slightly challenging
12 for you; is that fair?

13 **A.** Yeah, yeah, that's fair.

14 **Q.** So just bear in mind to tell us what you can recollect,
15 all right?

16 **A.** Okay.

17 **Q.** You describe in your statement about a difficult
18 childhood --

19 **A.** *(Witness nodded)*

20 **Q.** -- where Paula witnessed some traumatic events?

21 **A.** Yes.

22 **Q.** As far as you can remember, to the best of your
23 recollection, was this when her difficulties with her
24 mental health first arose?

25 **A.** Yes.

1 Q. Can you help us with roughly sort of what age would that
2 have been?

3 A. So, obviously, there's a nine-year age gap. From what
4 I've heard from my mum, there was even problems going
5 back to primary school. I remember witnessing for
6 myself my sister struggling with her mental health from
7 when I was about age 5 or 6, from when I can start
8 remembering.

9 Q. So quite early --

10 A. Yeah.

11 Q. -- when she was primary school age?

12 A. Yeah.

13 Q. I think in your statement -- perhaps we could have that
14 up, page 2, paragraph 10.

15 **THE CHAIR:** You will say if you want a break.

16 A. Yes, thank you.

17 **MS MALHOTRA:** You say that she suffered with her mental
18 health for the majority of her life and that there were
19 admissions in the last 20 years of her life; is that
20 right?

21 A. Yes, that's right.

22 Q. You make reference in your statement to Paula leaving
23 home at the age of 16?

24 A. Yes.

25 Q. Is that right?

1 **A.** Yes.

2 **Q.** Can you help us with whether that was connected with her
3 mental health at all?

4 **A.** Yeah, it was. So due to her mental health, she used to
5 have -- her and my mum had become quite -- well, they'd
6 just argue a lot and I think Paula then made the
7 decision to move out at the age of 16. She stayed close
8 but without them living under the same roof, they got
9 along a lot better.

10 **Q.** I'd like to turn to Bethlem Maudsley, so moving along
11 a little bit in time. Paula, I think at this stage, had
12 left home, and you describe she had her first admission
13 at Bethlem Maudsley when she was around that age --

14 **A.** Yeah.

15 **Q.** -- 16 years. Does that sound right?

16 **A.** Yes, that's correct.

17 **Q.** That's a hospital in South East London, is it?

18 **A.** As far as I know, yeah.

19 **Q.** Are you able to say how long she was there; whether she
20 was detained under the Mental Health Act?

21 **A.** I don't know that, sorry.

22 **Q.** I'd like to move forward in time, then, to the Linden
23 Centre, please.

24 **A.** Okay.

25 **Q.** Can you help us at all with when Paula first attended

1 the Linden Centre?

2 **A.** I can't remember when she first attended the Linden
3 Centre. She was in and out quite often. Throughout my
4 childhood, my mum tried keeping me a little bit away
5 from that. Yeah, sorry.

6 **Q.** That's okay. So perhaps if we have -- you explain that
7 she was in and out --

8 **A.** Yeah.

9 **Q.** -- and, appreciating what you say, that there was a big
10 age gap and that your mother tried to keep a lot of it
11 from you --

12 **A.** Yeah.

13 **Q.** -- can you help at all with whether she was detained
14 under the Mental Health Act? Was she there voluntarily
15 or involuntarily? Can you help with that?

16 **A.** Yeah, so, I don't know for sure that, sorry.

17 **Q.** You describe a number of admissions that Paula had. Are
18 you able to put a number on how many?

19 **A.** No, sorry.

20 **Q.** If we were to say five, it would --

21 **A.** It was more than that.

22 **Q.** -- between five and ten -- it was more than that?

23 **A.** Yeah, I would say.

24 **Q.** Do you know what ward she was in at the Linden --

25 **A.** No, sorry.

1 Q. Can you help us a little bit with what Paula told you
2 about the Linden Centre and what her impression was of
3 it, and then I'm going to ask you what your impression
4 of it was, but just tell us what did Paula tell you?

5 A. Oh, Paula hated it there. So, obviously, as I got a bit
6 older, I do remember more parts but she'd always say --
7 when she was in there, she'd say, "Oh, get me out,
8 I want to go", and she'd say, "Take me to the pub" or
9 something like that, and she just wanted to get out.
10 And somehow she was able to get out and then go there
11 and then sneak back again. So I don't quite know how
12 that happened. But yeah, she'd say that she'd make --
13 while she was there, the staff would make her feel less
14 than human, the way she was treated was disgusting, they
15 were understaffed and the stuff she witnessed was just
16 horrendous, the way people were treated, the stuff
17 people would do to themselves and the tools they were
18 given. Yeah, she was not a fan. She hated it.

19 Q. Did you visit Paula at the Linden Centre?

20 A. I did, a couple of times, yeah.

21 Q. What was your impression of it when you attended?

22 A. I didn't go in. I'd visit her as she'd come out and
23 then we'd go to a nearby pub and then she'd go back but
24 from -- like, I'd go into the reception area and wasn't
25 -- people didn't seem -- the staff didn't seem too

1 friendly and welcoming.

2 **Q.** I just want to ask you a little bit about Paula leaving
3 the Linden Centre, and you mentioned going to a pub and
4 that she would go out and then sneak back --

5 **A.** Yeah.

6 **Q.** -- to the Linden Centre. Is that something you saw her
7 doing? How do you know that?

8 **A.** Yeah, because I saw her do it, or she'd call me up and
9 say, "Please can you come and get me", she goes,
10 "I really just need to be out of here for a little bit".
11 And I -- I'd say no most of the time, or she'd say -- or
12 I think -- I'd say no because how was I supposed to get
13 her out? I was quite young but she was like, "Oh, meet
14 me here?"

15 "What are you doing out?"

16 And she was like "I can sneak back soon". She was
17 a rascal.

18 **THE CHAIR:** Did she give you the impression that she was
19 doing something she shouldn't be doing?

20 **A.** Yes, so where the Linden Centre is, there's a pub right
21 round the corner from it. I don't know whether it's
22 still open. But she'd say, "Oh, meet me here, I've got
23 out, snuck out for a bit". And then stay out for like
24 an hour or two and then she'd go back. But you'd have
25 to talk her back into going back because she didn't want

1 to but she knew it was in her best interests.

2 **MS MALHOTRA:** So the way you're describing it is Paula knew
3 she shouldn't have been going out, she sort of snuck out
4 and snuck back in.

5 **A.** Yeah.

6 **Q.** Does it follow that she wasn't on any sort of formal
7 leave from the centre --

8 **A.** No, she --

9 **Q.** -- or that she was doing it herself.

10 **A.** Yeah.

11 **Q.** Okay. You mention in your observations of the Linden
12 Centre in your statement -- and you've touched upon it
13 now in your evidence -- about it being short-staffed?

14 **A.** Yeah.

15 **Q.** Can you just explain what gave you that impression, that
16 it was short-staffed, bearing in mind you went to the
17 reception area and didn't go inside. So what gave you
18 that impression, that it was short-staffed?

19 **A.** So Paula, Paula would always say short-staffed, not
20 enough people. If you tried to call, you couldn't often
21 get through and one of our family friends, she'd mention
22 how there was never any staff. She'd go more often than
23 me -- obviously, I was quite young at the time, to begin
24 with -- and she'd say that it was short-staffed.

25 **Q.** You mention in your statement about Paula at one stage

1 having to share a room. Can you talk to us about that?
2 Why did she have to share a room and what impact did
3 that have on her?

4 **A.** She said that she had to share a room but she really
5 didn't like it. She said she felt unsafe. Yeah, she
6 just said she'd have to -- she had trouble sleeping
7 while she was sharing a room because she just didn't
8 feel safe at all.

9 **Q.** Were there any incidents concerning Paula or any other
10 patients absconding from the Linden Centre during
11 Paula's time there, that you became aware of?

12 **A.** Not to my knowledge.

13 **Q.** Did you become aware of any patient safety concerns at
14 the Linden Centre?

15 **A.** Only -- I mean, obviously Paula, from what she said when
16 she got knocked down by the staff.

17 **Q.** Let's talk about that.

18 **A.** Of course.

19 **Q.** You mention it in your statement --

20 **A.** Yeah.

21 **Q.** -- an incident, 15 October 2012.

22 **A.** Yeah.

23 **Q.** So quite some time ago.

24 **A.** Yeah.

25 **Q.** I think you say in your statement -- for anybody that's

1 following, it's paragraph 17, page 3 -- that Paula was
2 37 years of age at that time?

3 **A.** Yeah.

4 **Q.** Can you tell us, to the best of your recollection, what
5 happened on that occasion in 2012?

6 **A.** Okay, so Paula had told our family friend that she was
7 hallucinating and feeling strange. So our family friend
8 had called the Linden Centre in advance and said
9 "Paula's hallucinating, she's not" -- because sometimes
10 when Paula -- when she'd be struggling with her mental
11 health, sometimes it would make her a little bit -- it
12 would make her lash out a bit but our friend said,
13 "She's not lashing out, she's calm, she wants to come in
14 because she's hallucinating and she's scared".

15 So our friend took her there and they tried taking
16 her headphones from her and my sister didn't want to
17 give up her headphones. She wanted to listen to music,
18 the music was kind of grounding her, and she said that
19 she didn't want to give them up but she reached in her
20 pocket for something and the staff just tackled her to
21 the floor and they tackled our family friend as well,
22 for no absolutely reason, and they'd left a big
23 haematoma on Paula's leg, like a tennis ball size, and
24 then when she was saying that she needed medical help
25 for it, they wouldn't. They wouldn't let her get

1 medical help for it. They wouldn't let her go to the
2 A&E department for it, until one day, like a few days
3 later, it -- she felt like a pop in her leg.

4 **Q.** So when she did eventually go to the accident and
5 emergency department, what, if anything, was said about
6 her leg; do you know?

7 **A.** They -- sorry, what was the question?

8 **Q.** So it's about -- let's have a look at your statement.
9 That might help --

10 **A.** Yeah.

11 **Q.** -- because it was some time ago.

12 **A.** Yeah.

13 **Q.** So let's have a look at page 4, paragraph 22. So we're
14 just a little bit further forward from the initial
15 incident, when her leg was injured during, you've
16 described, a restraint.

17 Can I just ask, before we do look at that part of
18 your statement, you say that they wanted to take her
19 headphones from her and you've described music as being
20 important for Paula --

21 **A.** Very, yeah.

22 **Q.** -- and she needed to listen to music. Do you know, was
23 there any reason given why they wanted to take her
24 headphones from her?

25 **A.** Not that I know of. I don't know, sorry.

1 Q. Do you know what type of headphones? Was it a wire
2 headphones or was it wireless?

3 A. I'm guessing so because it was 2012 but, yeah, probably.
4 Yeah, that's the only reason why I can think that they'd
5 try taking her headphones.

6 **THE CHAIR:** How do you know about this incident?

7 A. Well, I remember visiting Paula in the hospital after
8 she'd had her operation and she told me about it but
9 also our family friend told me. But Paula told me by
10 herself.

11 **THE CHAIR:** Did your family friend tell you anything about
12 the sort of mood that -- you said she was hallucinating?

13 A. Yeah.

14 **THE CHAIR:** How did she present at the time that she went
15 into the hospital? Was she calm or --

16 A. Yeah, so our family friend, she said that she was calm
17 but she'd called in advance and said, "Paula, even
18 though she, like, lashes out sometimes, she's very calm
19 this time. She's just scared because she's
20 hallucinating and she knows the hallucinations aren't
21 real but she's scared of them". So yeah, she did say
22 that she was calm. So our family friend, she helped
23 Paula a lot throughout the years, so much. And she'd
24 seen her in her -- at her worst. So she was like -- she
25 was quite unusually calm this day. Yeah.

1 **THE CHAIR:** So she wasn't as she might be at her worst?

2 **A.** Yeah, yeah.

3 **THE CHAIR:** All right, thank you.

4 **MS MALHOTRA:** I'm just being asked to remind you to slow
5 down a little bit, if that's all right -- not that
6 you're doing anything wrong, but there's a transcript
7 that's being typed as you speak, so can I just ask you
8 to slow down slightly, please.

9 **A.** Okay, yeah.

10 **Q.** Thank you. So you mentioned that there was a pop in
11 Paula's leg, and we can see that that was on 20 October,
12 and then, at paragraph 22 here, you say that:

13 "... on 24 October [so four days after], there was
14 a ward review, Paula's injury was assessed again" --

15 **A.** Yeah.

16 **Q.** -- "by the team doctor and that day she was immediately
17 admitted to A&E for an operation."

18 **A.** Yeah.

19 **Q.** Can you remember if that operation took place at all?

20 **A.** Yes. It must have done because I remember visiting her
21 in the hospital. So, as far as I remember, yes, because
22 I do remember seeing her after, in the hospital.

23 **Q.** At paragraph 25 of your statement on page 5, you refer
24 to some compensation that Paula received?

25 **A.** Yeah.

1 Q. Was that as a result of the injury that she received --
2 A. Yes.
3 Q. -- to her leg --
4 A. Yes.
5 Q. -- which then caused her to have surgery?
6 A. Yes.
7 Q. I wonder if we could then move to two further topics:
8 one about Paula's medication and then I'm going to ask
9 you about substance use.
10 A. Okay.
11 Q. Firstly, you mention in your statement that Paula was
12 prescribed a depot injection --
13 A. Yeah.
14 Q. -- and that she'd been having depot injections since she
15 was 34 years old; is that right?
16 A. Yeah.
17 Q. That was for her mental health, was it?
18 A. Yes.
19 Q. That's an injection of medication that she received on
20 a regular basis, was it?
21 A. Yes.
22 Q. Every two weeks, I think?
23 A. Yes.
24 Q. Just tell us -- I mean, very difficult to summarise
25 Paula's reaction to that medication over a long period

1 of time but, if you were to try to characterise it or
2 summarise it in a way for us, did the medication help
3 her? Was she stable on it or?

4 **A.** Oh, it was so good.

5 **Q.** -- or did it make no difference?

6 **A.** The depot injection was the first thing I'd ever
7 witnessed that really helped Paula. It would make her
8 sleep for about two or three days straight after but she
9 was -- I mean, she stopped self-harming and everything
10 for quite a long time, it was the first thing that
11 seemed to actually work for her, yeah. It was like
12 a godsend, that depot injection.

13 **Q.** I'd like to then ask you about substance use. You refer
14 in your statement about Paula's use of drugs. Can you
15 help us with, to the best of your recollection, when did
16 that start?

17 **A.** I don't remember exactly when it started but I know that
18 it had been going on for a long time.

19 **Q.** Okay. Are you able to help us with whether that was
20 illicit drugs or prescription drugs?

21 **A.** Illicit drugs.

22 **Q.** Was she addicted to drugs, would you say?

23 **A.** Yes.

24 **Q.** Did Paula recognise that she was addicted?

25 **A.** Yes.

1 Q. What, if any, connection did you observe between Paula's
2 drug use and her mental health?

3 A. So if she'd -- you could always tell when she'd done
4 a lot of drugs but that would also send her a little --
5 like she'd start hallucinating and start making -- start
6 thinking that things are happening that are not, and
7 then she'd seem to get control of it, and stop. But
8 I don't know whether it was because of where she lived
9 or the people she knew, or I don't know what it was.
10 But she'd always go back to her cocaine addiction.

11 Q. Can you help us not so much in the community, because
12 we're going to come and speak about that in a moment --

13 A. Yes.

14 Q. -- but just in terms of that period of time when she was
15 at the Linden Centre: how was her drug addiction managed
16 at that time?

17 A. Oh, are we going back to 2012 or are we more recent?

18 Q. Well, if you're able to help us.

19 A. I don't know about that.

20 Q. Just whatever you're able to recall and then see if you
21 can place it in time for us.

22 A. So with the Linden Centre, I'm not too sure how that was
23 managed but I do remember she was offered rehab. She
24 was given lots of brochures for rehab, promised that she
25 could go, all she had to do was choose one and fill in

1 a form for it. But nothing ever come of it. Even when
2 she tried asking for follow-ups of, "When am I going to
3 rehab?", it's like nobody knew what she was talking
4 about, even though it was something she was promised and
5 had all the brochures for.

6 **Q.** You mentioned brochures: do you know where she got those
7 from?

8 **A.** I think it was Open Road.

9 **Q.** Do you know how she came to be involved with Open Road
10 at all?

11 **A.** I don't. Sorry.

12 **Q.** In your statement, perhaps we can have that up, it's
13 page 5 and 6, paragraph 29. Towards the bottom of the
14 page there, we can see that you list six occasions where
15 Paula had overdosed. Can you tell us what you knew
16 about them at the time?

17 **A.** I'm not too sure about the 2009 one. I'm only really
18 familiar with the last few. I think my sister -- so
19 with the -- especially January 2020, I think Covid had
20 a big part to play in her mental health because,
21 obviously, with all the restrictions and everything.

22 **Q.** Just explain that a little bit more to us, please. What
23 impact did the restrictions have on her mental health?

24 **A.** So she felt very alone. I'd go visit her but I'd have
25 to stand at the door because I was working with strictly

1 Covid patients at the time. So (... redacted ...)
2 I couldn't really visit them, so I'd just have to stand
3 at the door and see them when I could, and I think she
4 felt very isolated and alone and it took quite a toll on
5 her mental health, as I'm sure it did a lot of people.

6 **Q.** I wonder whether you can help us: so at around this
7 period of time, to the best of your recollection, was
8 there an overemphasis on Paula's drug addiction over her
9 mental health, would you say, or could you not comment
10 on that?

11 **A.** I did notice that the worse her mental health got, the
12 more drugs she took, which in turn the worse her mental
13 health got. It was a bit of a back and forth with that.

14 **Q.** Just going back to the Linden Centre. Were you ever
15 asked by the medical professionals who were treating and
16 caring for Paula about the extent of her substance use
17 and its connection with her mental health? Is that
18 something that was explored with you?

19 **A.** I wasn't ever asked that.

20 **Q.** Generally, in terms of engagement with you, did you have
21 any interaction or did anyone in your family have
22 interaction with members of the medical staff at the
23 Linden Centre?

24 **A.** Not really, no.

25 **Q.** You say "not really". What do you mean by that? Was

1 there some interaction --

2 **A.** Well, our family friend, the one that would help Paula
3 all the time, she'd tried calling. She was also
4 trying -- her brother was in there at the same time, as
5 well, so she was trying to help him as well. But she
6 said she just didn't feel like she was getting anywhere.

7 **THE CHAIR:** You've talked about Paula being affected by
8 Covid and being isolated. Where was she living at that
9 time?

10 **A.** She was living in a flat in the same town as me, by
11 herself though, with her cats.

12 **THE CHAIR:** Right.

13 **MS MALHOTRA:** I'd like to move on to events in 2021 --

14 **A.** Okay.

15 **Q.** -- okay? Before we talk about November 2021, just
16 generally, give us an idea, if you can, about how Paula
17 was at this time?

18 **A.** It was the worst I'd seen her in a long time. Like
19 I mention, the depot injections seemed to really help
20 her but then 2021 come around and she was just -- she
21 was just sad. She was really struggling with her mental
22 health.

23 Yeah, like I said, I don't think Covid helped but
24 I saw a bigger increase in the amount of drugs she was
25 taking. Yeah, she just -- it felt like we was going

1 backwards with her care again.

2 **Q.** At this time, she had a social worker in the community,
3 did she?

4 **A.** Yeah, she did but she was seeing the social worker less
5 and less. Again, that was -- when I asked why, that was
6 blamed on Covid, as well. I don't think she really
7 got -- she had a social worker that she did get along
8 with and then she had one that she didn't really like.
9 Yeah, she was struggling a lot.

10 **Q.** Was she still going in and out of the Linden Centre at
11 this time?

12 **A.** No.

13 **Q.** No. So you've described perhaps difficult dynamics --

14 **A.** Yeah.

15 **Q.** -- with one of the social workers?

16 **A.** Yeah.

17 **Q.** Can you help us with how her drug use was being managed
18 at this time?

19 **A.** It wasn't. Like I said, the only thing that happened
20 with her drug use or the only thing they mentioned was
21 the rehab. Other than that, nothing was really
22 mentioned about it.

23 **Q.** What about her mental health? She was still on her
24 depot injection but any other support that you can
25 recall at this time?

1 **A.** Not really, no. No, she -- like I said, she was
2 struggling and the more she struggled, the less help she
3 got, it seemed like. She was even saying -- she was
4 asking that when her social worker come round, can she
5 come round just her, because the social worker kept
6 bringing strange -- in Paula's words -- "strange men"
7 into her flat. Due to Paula's past, that made her feel
8 very uncomfortable, which she expressed to the social
9 worker but the social worker just wouldn't listen. She
10 said, "Well, they've got to be trained somehow".

11 And I, in the end, had to get on to the social
12 worker and said, "You can train them with the person
13 before, the person after, but this is really affecting
14 Paula's mental health, please don't bring strange men
15 round".

16 **Q.** Did that then stop after you intervened?

17 **A.** Yeah, but it's sad that they wouldn't take Paula's word
18 for it. Paula asked them not to and they wouldn't
19 accept it.

20 **Q.** Do you know how many times that happened?

21 **A.** No. I can recall twice, Paula mentioning to me
22 personally, but I don't know how many times it happened.

23 **Q.** Okay. At this time, was Paula self-harming?

24 **A.** No, she'd gone quite a while without self-harming.
25 I don't -- no, I don't think she was.

1 Q. What about suicidal ideation? Was she expressing that
2 around this time?

3 A. No, Paula said -- it's quite weird and I don't
4 understand it, but that's not for me to understand.
5 She'd say she wanted to harm herself but not to actually
6 die. It was just an overwhelming feeling that she'd
7 get. And she wasn't self-harming at the time because
8 she'd feel like she'd let me down if she did, even
9 though I'd stated that she didn't let me down.

10 Q. I'd like to turn to events of November 2021. Are you
11 all right to carry on?

12 A. Okay, yeah.

13 Q. Now, in November, it was around about 17 November, when
14 Paula had a drug overdose and she was taken to
15 Broomfield Hospital.

16 A. Mm-hm.

17 Q. Then it seemed she was discharged and then, on the 18th,
18 she went back to the accident and emergency department?

19 A. Yeah.

20 Q. Then on the 19th, there was intervention with the home
21 treatment team?

22 A. Yeah.

23 Q. She attended A&E and she was then at a Mental Health
24 Liaison Team suite. Then, on 22 November, it seems that
25 she was discharged. I want to ask you about that: that

1 series of events and that time period?

2 **A.** Yeah.

3 **Q.** Starting then with 17 November: can you tell us about
4 your recollection of events then, with the drug overdose
5 and the attendance at hospital?

6 **A.** Yes, so Paula had called me on the 17th to say that
7 she'd taken an overdose, so I drove back from work. I'd
8 worked relatively close to her. I called the ambulance
9 for her and she was taken into hospital and checked over
10 but they'd determined that it wasn't a very big
11 overdose, as they called it, so they just discharged her
12 at the same time and I met her at her house after she
13 got home. She was just -- yeah, she was just really
14 down. She'd been saying stuff about her neighbours.
15 I don't know whether that was her paranoia or what but,
16 yeah, she was just really down. But discharged the same
17 day, even though she was saying that she's going to do
18 it again.

19 **Q.** I'm sorry that it's probably very difficult to talk
20 about and I'm sorry to probe you on this but, in regards
21 to her overdose, did she tell you at all what her
22 intentions with that overdose were?

23 **A.** She didn't at that time.

24 **Q.** When she was at the accident and emergency department
25 and then discharged, do you know if she was assessed at

1 all? Was she assessed for her mental health at that
2 stage?

3 **A.** So I took her in -- I remember taking her -- is that on
4 the 17th or the 18th?

5 **Q.** Let's just stick to the 17th. Yeah.

6 **A.** Okay, I don't really know because I met her back at hers
7 after.

8 **Q.** In terms of her discharge from hospital, do you know if
9 there was a plan that she was discharged with? Was she
10 provided any information about who she could contact in
11 a crisis, for example?

12 **A.** Not to my knowledge. She was in contact with
13 Samaritans. They'd actually call her every day to make
14 sure she was okay. But, other than that, I don't know.
15 She said she didn't hold much hope in the crisis team.
16 She said she could call them when she was in a crisis
17 and not a lot would happen but she really, really had
18 a lot of admiration for the Samaritans. She said they
19 seemed like they actually cared.

20 **Q.** So that was the Samaritans. You mentioned crisis and
21 I didn't quite catch who you referred to, but was
22 there --

23 **A.** The crisis team.

24 **Q.** -- another team that she was in touch with?

25 **A.** Yeah, the crisis team.

1 Q. Crisis.

2 A. I know she'd always be told she should call the crisis
3 team if she's having a crisis but, yeah, she said when
4 she -- every time when she had called the crisis team
5 she felt like they didn't do a lot, whereas the
6 Samaritans, she felt like she could talk to them and
7 they weren't rushing her off the phone. And, like
8 I said, she had a lot of admiration for them. And
9 they'd call her to check on her as well, which I thought
10 was like they actually cared.

11 Q. So in terms of the crisis team, Paula had called them
12 before?

13 A. Yeah.

14 Q. And she didn't have a positive experience?

15 A. No.

16 Q. Can you just explain why she felt that they didn't do
17 a lot, in the words that you used?

18 A. She felt like they'd just talk to her and she felt like
19 they'd rush her off the phone and she wouldn't actually
20 get anywhere, like with her treatment or not and she'd
21 get no extra help. When she was calling, she was
22 wanting help.

23 Q. I'd like to move on -- sorry, just to go back to this,
24 before we do move on to the next few days --

25 **THE CHAIR:** Sorry, could I just ask, when she left the

1 hospital on the 17th, was that when they said to her
2 "Phone the crisis team"? When was she --

3 **A.** I don't -- I'm not too sure what happened on the 17th
4 when she left. I had to get home because I've got my
5 family. I had to get home to my children.

6 **THE CHAIR:** Yes.

7 **A.** So, yeah, she said -- I know she made it home because
8 I made sure that I constantly kept in contact with her
9 but she just said they done nothing. That's what she
10 told me.

11 **THE CHAIR:** So you don't know when it was that she was put
12 in touch with the crisis team?

13 **A.** So the social worker would tell her to call the crisis
14 team.

15 **THE CHAIR:** Right. Thank you.

16 **A.** Sorry.

17 **THE CHAIR:** No, that's fine. That makes perfect sense.

18 **MS MALHOTRA:** I think my question is probably much the same
19 as the Chair's but I just wanted to clarify if there was
20 any follow-up that was going to happen. Was Paula
21 expecting somebody to contact her afterwards or do you
22 not know?

23 **A.** I don't know about that.

24 **Q.** Let's move on, then, to the 18th, to the following day.
25 You mention in your statement -- for those that are

1 following, it's paragraph 41 at page 7 -- that she
2 attended the accident and emergency department again?

3 **A.** Yeah.

4 **Q.** Which hospital was this?

5 **A.** That was at Broomfield as well.

6 **Q.** Can you tell us, to the best of your recollection, why
7 did Paula go back to the accident and emergency
8 department that day?

9 **A.** She was telling me she had an overwhelming feeling that
10 she was going to take her life. Again, she was saying
11 the specific method that she wanted to do -- I don't
12 know whether I'm allowed to say it but she'd say the
13 specific method that she'd want to do. But, again,
14 she'd say it's not like she wanted to die; she just
15 needed some kind of relief. But I encouraged her to go
16 to A&E. I took her there and she -- she kept saying
17 it's -- "Nobody cares", and I kept saying, "They will,
18 they will".

19 And when I took her there, she -- we was trying to
20 get help and I remember going into a room with her and
21 they were saying, "Oh, you was here yesterday". Not
22 quite to that extent but that's how it felt. There was
23 no compassion in the nurse that we saw and, yeah, we
24 were just told again, "No beds".

25 **Q.** Can I just ask you a little bit more about that. So you

1 took Paula?

2 **A.** Yeah.

3 **Q.** Can you remember what time of day it was: was it at
4 night or during the day?

5 **A.** It was later in the -- I can't remember exactly what
6 time but I know it was a bit later.

7 **Q.** So late in the afternoon?

8 **A.** From what I recall, yeah.

9 **Q.** You say that she was seen by a nurse. Do you know if
10 that was a mental health nurse?

11 **A.** No.

12 **Q.** A triage nurse, maybe?

13 **A.** No, it was just -- no, it wasn't a mental health nurse,
14 I don't think.

15 **Q.** Was Paula seen by a mental health nurse?

16 **A.** I'm not too sure. She was told there was no beds and
17 then we was sent home, so no. Not to my knowledge.

18 **Q.** When you say you were told there were no beds: beds for
19 what?

20 **A.** Because we were saying about -- Paula wanted to be
21 admitted into the mental health unit because of
22 everything, but we was sent home. I don't know why we
23 were sent home or who we were sent home by. Sorry,
24 I can't answer that. I can't quite remember that at the
25 moment.

1 Q. That's okay but Paula had said that she wanted to be
2 admitted to --

3 A. Yes.

4 Q. -- the mental health unit?

5 A. Yes.

6 Q. There was some discussion about there being no beds?

7 A. Yes. That I do know.

8 Q. Okay. Can you remember who said that about there being
9 no beds? Was it the same nurse that you'd seen
10 throughout or was it somebody different?

11 A. I can't remember, sorry.

12 Q. Tell us about what the resolution of that was: was it
13 that Paula left the hospital or she waited at the
14 hospital for a bed?

15 A. No, we left. I took her home -- yeah.

16 Q. How did you feel about having to take her home?

17 A. Frustrated, I remember that. It just felt like we was
18 getting nowhere and for her to accept, like, my offer to
19 go to the hospital before she'd done anything -- again,
20 I know she had taken the overdose the day before but
21 before she'd done anything again that day -- I thought
22 that we were getting somewhere and that this was going
23 to be great because then she'll be in a safe place,
24 and -- and she just was getting more and more defeated
25 by the day. Both of us.

1 Q. Was there a level of acceptance that she needed to be in
2 hospital but there just wasn't the capacity available
3 for her at that time?

4 A. I don't really know. It was just -- it just felt like
5 we was just being told the same thing. It felt like
6 Groundhog Day, again and again: no beds, no beds.

7 Q. Just before Paula was discharged, I'm going to ask you
8 the same questions I asked before about what was she
9 told? Was there going to be any follow-up? Was she
10 given details about who to contact in a crisis? How was
11 the fact that there weren't any beds available and that
12 she was expressing suicidal ideation at that time, what
13 kind of was in place? Was there a plan?

14 A. I'm not too sure if there was so much of a plan but I'm
15 pretty sure that we got told that somebody would visit
16 her at home for home care.

17 Q. Is that the Home Treatment Team? Does that --

18 A. I think so, yeah.

19 Q. Okay, possibly. That they would visit her at home?

20 A. Yeah.

21 Q. Do you know when they would visit?

22 A. No, we didn't get told a day or time or anything.

23 Q. Was she given any information about who she could
24 contact in a crisis?

25 A. I can't remember that, sorry.

1 Q. How was Paula in all of this, when you got her back
2 home? How, was she?

3 A. She wasn't her -- she just seemed defeated. She was
4 getting -- there was so little fight left, whereas
5 before she'd be making this big "I need help, aargh",
6 but every day it was -- she was quieter and quieter.

7 Q. So just going back to the beds, you say in your
8 statement that there were no beds locally or nationally?

9 A. Yeah.

10 Q. Was there any alternative that was offered to Paula?

11 A. No.

12 Q. She was discharged, was she, from the accident and
13 emergency --

14 A. Yeah.

15 Q. I'd like to move, then, to 19 November. You talk about
16 a visit from the Home Treatment Team. Can you help us
17 with that at all?

18 A. Yeah. So she -- sorry, bear with me one second.

19 Q. That's all right. Take your time. We're in no rush.
20 If it helps at all you can have your statement in front
21 of you, if it helps?

22 A. That's okay, I've got it here.

23 Q. Just take your time.

24 A. Yeah, okay. So on that day, she did go to A&E again,
25 and she --

1 Q. So this was the third day in a row?

2 A. Yeah. Well, she'd contacted the Samaritans and, yeah,
3 I remember her going into A&E and actually -- so where
4 A&E is, you've got the -- like, the main part for broken
5 legs and stuff and then you've got the mental health
6 unit around this time and she actually got taken into
7 there and was given like an emergency bed.

8 Q. So just explain that to us. There's a sort of mental
9 health unit within the accident and emergency
10 department?

11 A. Yeah.

12 Q. Was that the first time that she'd been taken into that
13 smaller unit?

14 A. Yeah. On this occasion, yeah. I think she might have
15 been there before because one of the staff members knew
16 of her.

17 Q. So on the earlier occasions when you had been with her
18 to accident and emergency before --

19 A. She hadn't been to that bit.

20 Q. She hadn't been?

21 A. No.

22 Q. So where was she being spoken to? Was it in the
23 reception of the accident and emergency or in
24 a consultation room?

25 A. In just in a consultation room.

1 Q. So this unit, this mental health unit, on this occasion,
2 on the 19th, that she was taken to, there was a bed
3 there, you said?

4 A. Yeah.

5 Q. And what else? Just describe it to us, please.

6 A. Well, she went off to that bit. I only saw the
7 reception part and I took her her stuff and, yeah, just
8 left. It's like -- I was in tears because, one,
9 I thought she was gonna actually get help but, two, it
10 was really sad, as well, seeing her. She looked like
11 a little lost soul, bless her.

12 Q. So she went into the unit; you stayed outside?

13 A. *(Witness nodded)*

14 Q. Do you know if she was assessed by a mental health
15 professional?

16 A. So I just had to leave her there. I got told she was
17 staying there until -- they were waiting for another bed
18 in, I don't know, like the Linden Centre or somewhere,
19 to become available. I think that's the place where
20 people are held -- I don't know, sorry -- until a place
21 for the Linden Centre or somewhere becomes available.
22 She was there and then I'd just have to keep calling to
23 check on her.

24 Q. I think it's the -- you refer to it as the Mental Health
25 Liaison Team suite --

1 **A.** Okay.

2 **Q.** -- in your statement. So just describe to us -- you've
3 explained how you were feeling: happy that she was going
4 to be getting some help but also really sad to leave her
5 and see her there?

6 **A.** Yeah.

7 **Q.** How was Paula at this time?

8 **A.** Like I said, she was -- she was just quiet. She just
9 wasn't herself. It felt -- looking back, I know she was
10 just giving up but I didn't realise that at the time.

11 **Q.** Are you all right?

12 **A.** *(Witness nodded)*.

13 **Q.** So you describe in your statement Paula staying there?

14 **A.** Yeah.

15 **Q.** I think she stayed there until the 22nd?

16 **A.** Yeah.

17 **Q.** Were you able to speak to her whilst she was there?

18 **A.** So I didn't speak to her -- well, yeah, she had her
19 phone. Sorry, I forgot about that. She did have her
20 phone.

21 **Q.** Okay. Just explain to us, then, what happened on the
22 22nd, please?

23 **A.** My uncle passed away and we'd had about six deaths,
24 seven deaths, in a really short amount of time and
25 I know my sister had her phone and I didn't want her

1 finding out, I don't know, on like Facebook or
2 something. So I called the hospital and I said --
3 I explained, "Death's a trigger for my sister. She's
4 not taking it well so, as soon as she finds out about my
5 uncle, she's going to have a really bad time of it".

6 I said, "I'm coming to tell her face-to-face because
7 I said I don't want her finding out", and I said, "Can
8 you just keep her phone away from her?"

9 And they said, "Well, luckily enough, she's just
10 come to put it on charge, so I'll just say it hasn't
11 charged or whatever".

12 So I said, "Okay, I'll be there in about 20 minutes,
13 half an hour", or something like that.

14 So when I dropped my son off and then drove to the
15 hospital, and I was close by there and my phone rung,
16 and they said, "Oh, just so you know, the doctors have
17 been to see Paula and she's getting discharged".

18 And I said, "Well, what do you mean?" I said,
19 "I literally called 20 minutes ago to say I'm coming to
20 tell her that my uncle has just passed away, and death's
21 a trigger for her". I said, "I don't understand how
22 she's been discharged".

23 So anyway, I turned up and I went to see Paula. She
24 was in this, like, room and I've got taken to her and
25 I explained my uncle had died and, with that, my sister

1 started having a panic attack and she was like waving
2 her hands at her face and struggling to breathe, and I'm
3 trying to get her to sit down because I'm panicking,
4 I don't know what to do. She's really panicking. And,
5 with that, a doctor's come and dropped her bag at my
6 feet and said, "You need to take her now, we need the
7 bed". And I said, "Can you not see this?" And he said,
8 "Sorry, but we need the bed".

9 So I had to take her out like that. I knew she was
10 like trying to jump -- she kept saying she was going to
11 jump out of the car on the way home. But to try and
12 make a joke of it, like I always do, I said, "If you do
13 that and damage my car, I'm going to be mad", and it
14 kind of brought her round a little bit, and she was like
15 "Okay, I won't".

16 So, yeah, I took her home and, again, it was just,
17 she was even quieter then, which wasn't like her.

18 **Q.** I want to ask you a little bit more about that.

19 I appreciate it's difficult.

20 **A.** That's okay.

21 **Q.** We can take it slowly and I can refer you to your
22 statement if that's helpful, as well?

23 **A.** Okay.

24 **Q.** So far as you were aware, before you had rung to speak
25 to Paula about your uncle, who had sadly passed, was it

1 your expectation that she was going to be staying there
2 and transferred --

3 **A.** Yeah.

4 **Q.** -- to somewhere else, where there was a bed?

5 **A.** Well, yeah, because we were told, as soon as a bed
6 becomes available, she'll have a bed. We were just
7 waiting for a bed. But, at that time, there was no beds
8 available.

9 **Q.** Okay. So your expectation was that she was going to go
10 somewhere else --

11 **A.** Yeah.

12 **Q.** -- not that she was going to be discharged?

13 **A.** No.

14 **Q.** Okay. So just taking it in stages, then, hearing that
15 she was going to be discharged, what was your reaction
16 to that?

17 **A.** I was just in shock because she was still constantly
18 saying that she feels like she's going to try and take
19 her life and she very specifically said how she wanted
20 to take her life, as well.

21 **THE CHAIR:** Who did she say that to, apart from you?

22 **A.** She was saying it to anybody that would listen. She was
23 just saying, "I need help. I feel like I want to take
24 my life".

25 **THE CHAIR:** Did you hear her say that to the doctors?

1 **A.** Yeah. Yeah.

2 **MS MALHOTRA:** So that was on the days earlier?

3 **A.** Yeah.

4 **Q.** On the days earlier. But just trying to understand,
5 then, how you go from that to then being discharged, do
6 you know what she had told the medical professionals
7 whilst you weren't there?

8 **A.** No.

9 **Q.** Do you think it's possible that she might have said she
10 was fine?

11 **A.** Maybe. When she was in the car with me, she said that
12 there's -- because I said, "Well, let's take" -- because
13 she kept saying that she felt like she was going to jump
14 out of the car, and I said, "Well, let's take you back
15 there", and all she kept saying was, "There is
16 absolutely no point. Nobody cares. Nobody wants to
17 help me".

18 So maybe she just said it to get out of there and
19 that was her way of being able to ... die.

20 **Q.** So knowing what you had known and heard from Paula in
21 the days before --

22 **A.** I'd have taken her back.

23 **Q.** -- no, but did anybody talk to you before that decision
24 to discharge was made?

25 **A.** No, nobody. Like I said, all I got told was, "Come and

1 pick her up, she's been discharged". And I said, "You
2 know I'm on my way".

3 Q. You were on your way for a different reason.

4 A. Yeah.

5 Q. Do you know if any other family members or friends were
6 spoken to --

7 A. Nobody, no.

8 Q. -- before that decision to discharge her was made?

9 A. No.

10 Q. No, you don't know or no they weren't spoken to?

11 A. No, they weren't spoken to.

12 Q. Just trying to put yourself back, and I know that's
13 probably very difficult, but putting yourself back in at
14 that time, how did that feel for you?

15 A. I was so angry. I was so angry and I felt -- just,
16 again, I was starting to feel defeated and do you know
17 what's one of the worst things is Paula always used to
18 say, "Nobody listens to me", and I used to -- "It can't
19 be that bad, it can't be that bad", and then I witnessed
20 it all for myself and I felt so guilty for ever doubting
21 her because she'd say, "They treat me awful and they
22 don't listen and I say this, and they" -- and I used to
23 think, you know, they're professionals, of course
24 they're -- that's -- and I know a part of me used to
25 think maybe she's exaggerating due to her mental health.

1 And then I witnessed it all for myself, and I just --
2 and how -- like, she was in one of the most vulnerable
3 states and she was just being passed off like she's
4 nothing.

5 **Q.** You say that you witnessed it for yourself. Describe to
6 us what exactly you witnessed?

7 **A.** Being told there's no beds and just the nurses being
8 cold -- really cold with her, and just being dismissed
9 so easy. And people just not listening. People talking
10 over her because she's trying to explain how she feels
11 but they've got other people to see. And that's --
12 I could see why she'd think the way she thought.

13 **Q.** So I just want to ask you about speaking about the
14 passing of her uncle --

15 **A.** Yeah.

16 **Q.** -- and that conversation that you had to have with
17 Paula. Where were you when you had that conversation?

18 **A.** We was in a room in the mental health unit in the A&E,
19 where I'm guessing her bed was. I didn't get to ask her
20 too many questions because, obviously, I went in and
21 I led with that because I thought I don't want to do
22 this outside because, as death was a trigger for her and
23 because we'd dealt with so much of it, I thought if
24 I could just tell her there, then, if anything did
25 happen, then maybe I'd have help.

1 Q. So you described a doctor. How do you know they were
2 a doctor?

3 A. Because he said, "Hello, I'm Paula's doctor", and
4 I didn't get his name but he's -- like, "She's been
5 discharged, can you take her now and we need the bed".
6 And I said, "Can you not see she's having a panic
7 attack?" And he's like, "I'm so sorry but we need the
8 bed".

9 Q. So, as a result of receiving this news, which was
10 a trigger for her as you've described --

11 A. Yeah.

12 Q. -- was there a further assessment of her mental health
13 before she was then discharged, as a result of that?

14 A. No, no, I had to take her through -- back through the
15 other waiting room for A&E, because that's the way you
16 get out of the mental health unit, while she's still
17 having a panic attack.

18 Q. Did anybody stop her and ask if she was okay or if you
19 needed some time? Maybe not in the mental health unit,
20 if they needed it, but --

21 A. No, no, we just left.

22 Q. I didn't quite catch your last answer. You said, "No,
23 we just left"?

24 A. Yeah.

25 Q. You've described how Paula was in the car journey. When

1 she got home, can you tell us how she was once she got
2 home?

3 **A.** She just said she was tired and she said she hadn't
4 slept properly whilst being there, and I offered to stay
5 with her for a bit. Obviously, I had to go pick up my
6 son, as well. But she's like, "No, I'm okay, love, I'll
7 be fine".

8 **Q.** So, again, I've asked you before about was she
9 discharged with a plan in place? Was somebody going to
10 be following her up? Was someone going to visit or
11 call? Can you tell us anything about that?

12 **A.** I didn't get any of that information. As far as I was
13 concerned she was just discharged.

14 I even had to ask whether she wanted to stay at mine
15 but she didn't and it's like, sometimes, if she was
16 having a bad day, I'd swing by and pick her up on my way
17 home from work and just sit her on the sofa and feed
18 her, and that would make her happier again just being
19 around us, but she didn't want to even do that that day.

20 **Q.** From that discharge on 22 November 2021, did she go back
21 to the accident and emergency department, as far as
22 you're aware?

23 **A.** No.

24 **Q.** And she didn't go back to the Linden Centre?

25 **A.** Not that I know of, no.

1 Q. She was under the care of the community team; is that
2 right?

3 A. Yeah.

4 Q. I think it's the Home Treatment Team?

5 A. *(Witness nodded)*

6 Q. Can you tell us about what you observed with the Home
7 Treatment Team and how Paula interacted with them?

8 A. I don't really know. I know that she kept just not
9 receiving her medication in that time, and what they
10 were saying to her is that she'd have to go pick it up
11 from the pharmacy on a daily basis but she'd fractured
12 her back. So, yeah, um ...

13 Q. When did she fracture her back?

14 A. I think that was -- I can't remember but it was like
15 between November/December, time.

16 Q. Okay. So this wasn't her depot injection?

17 A. No.

18 Q. This was other medication?

19 A. Yeah.

20 Q. Then she was told to pick it up from the pharmacy. Was
21 she still having her depot injections at this time?

22 A. Yeah.

23 Q. Would she see a nurse for those depot injections?

24 A. Yeah, she said that was -- so before she'd see a nurse
25 and she'd get, like, conversation and they'd ask her how

1 she's doing, she said but, with the Covid restrictions
2 she was getting less and less and less time with
3 somebody. So they'd just come and give her the
4 injection and go, or -- yeah.

5 **Q.** So it wasn't a sort of in-depth --

6 **A.** No.

7 **Q.** Okay. Do you know how long, roughly, those appointments
8 would be?

9 **A.** Minutes.

10 **Q.** Would they come to her house or would she go --

11 **A.** I think she'd go to her doctor's for it.

12 **Q.** I think you mentioned earlier that it was fortnightly.
13 Was that the same --

14 **A.** I think so, yeah.

15 **Q.** So she was having that depot injection fortnightly. Was
16 there, as far as you're aware, was there any other
17 interaction with anyone from mental health?

18 **A.** No, no.

19 **Q.** You say in your statement that Paula was discharged from
20 the Home Treatment Team on 6 December --

21 **A.** Yeah.

22 **Q.** -- 2021. Can you help us with how or why that happened?

23 **A.** I don't know. I have no idea.

24 **Q.** Were you spoken to before she was discharged?

25 **A.** No.

1 Q. At that time, how was her substance use being dealt
2 with?

3 A. It wasn't being dealt with. She was still using.

4 Q. Give us an indication of how Paula was at that time, in
5 December 2021?

6 A. Um, I don't know. She just -- she wasn't herself.
7 I couldn't put my finger on why. She just wasn't
8 herself. I can't say exactly -- exactly how.

9 Q. Was she expressing thoughts of ending her own life?

10 A. No. I mean, I suppose she was drinking more. I picked
11 her up Boxing Day and I spoke to her at about 10.40 and
12 I said -- I was supposed to pick her up at 11.00 --
13 I said, "I might be about 15 minutes late", I said,
14 "I might not make it at 11.00", I said and she was like
15 "Oh, for God's sake, hurry up". I said "Okay".

16 I got there at about 11.05 and in that time she'd
17 got absolutely hammered. So drunk. And I said to her
18 "Are you coming -- it's Boxing Day", I said, "You need
19 to pull yourself together, because we've got kids".

20 And again, I just sat on the sofa and fed her. She
21 just wanted paté. So I fed her cheese and crackers and
22 stuff and tried to sober her up a little bit but she was
23 getting quite drunk a lot, so I suppose that's not -- it
24 wasn't her. It wasn't normal for her.

25 Q. I'm going to move on to 6 January 2022. I don't propose

1 to ask you much about it, other than sadly that was the
2 day that Paula died --

3 **A.** Yeah.

4 **Q.** -- and you sadly found her --

5 **A.** Yeah.

6 **Q.** -- is that right? I'm going to move on to ask you three
7 more topics.

8 **A.** Okay.

9 **MS MALHOTRA:** One is the inquest; and, secondly,
10 investigations post-Paula's death; and your
11 recommendations.

12 But I think, before we come to talk about those
13 topics, I think it's probably now, Chair, a good time to
14 take a break, if that's all right, until 11.30?

15 **THE CHAIR:** 11.30.

16 **(11.14 am)**

17 **(A short break)**

18 **(11.37 am)**

19 **MS MALHOTRA:** Thank you, Chair. I think we're ready to
20 carry on with the witness's evidence.

21 So, Sam, we left off about to start talking about
22 the inquest. So I mentioned I've got three topics to
23 cover with you: the inquest; investigations post-death;
24 and recommendations that you invite the Chair to
25 consider.

1 **A.** Yeah.

2 **Q.** Turning then to the inquest. I'm going to, if it's
3 helpful to you, just signpost where we are in your
4 witness statement. So page 11, paragraph 65. If that's
5 helpful to you.

6 **A.** Yes.

7 **Q.** You say here that the inquest took place on 27 October
8 2023. What I wanted to ask you about is what you say at
9 paragraph 66 of your statement. I'll ask that it's put
10 up on the screen, so that everyone has the benefit of
11 seeing it. It's page 11, paragraph 66.

12 You talk there about legal representation. You
13 weren't legally represented; is that right?

14 **A.** I wasn't, no.

15 **Q.** Do you know if the Trust attended at all? Was there any
16 healthcare professionals that attended the inquest?

17 **A.** No.

18 **Q.** Okay. So it was yourself and the coroner alone; is that
19 right?

20 **A.** I did have two people come with me but that was it.

21 **Q.** In terms of not having legal representation at the
22 inquest, is there any observation that you want to make
23 about that?

24 **A.** I wasn't aware I was allowed any. I had a family
25 liaison officer and I'd expressed to her many times how

1 disgusted I was in the care that my sister received.

2 And I also told her that I wanted to fight it but I was
3 told, "No point trying to fight it; you won't ever get
4 anywhere".

5 **Q.** This is a police family liaison officer?

6 **A.** I'm unsure, sorry. It was just a family liaison officer
7 I was assigned.

8 **Q.** Okay. Right. Is there anything else that you wanted to
9 say about the inquest that I haven't asked you?

10 **A.** No. I was -- I was unable to get her medical records.
11 I kept asking about her medical records and whether
12 I could have them but I was turned from one place to
13 another place to another place, and I just didn't get
14 anywhere with it.

15 **Q.** I'd like to move on and ask you about investigations
16 post-Paula's sad death. To help you, it's page 12 --
17 I'll ask if that can be put up, please. Page 12,
18 paragraph 68 of your statement. Right.

19 We can see here that you make reference to an After
20 Action Review report that was conducted by EPUT. Just
21 tell us about how that came about? Was it a report that
22 you were told about there was going to be: a report that
23 was going to be prepared, or was it something that you
24 were told about after the event?

25 **A.** So I was told that the EPUT After Action Review, that

1 they had absolutely no issues and that they was pleased
2 with the way Paula was treated. And I then argued this,
3 obviously, because I wasn't happy myself, and I was
4 trying to fight it. I was trying to say, "Look, I'm not
5 happy. The way my sister was treated was not right.
6 She was treated, in my opinion, disgusting". But she
7 kept getting promised like the bed and she'd get
8 promised the rehab and she'd get promised this and that,
9 and nothing ever come to fruition.

10 So after I received that I put together a list of
11 questions to put forward to EPUT, and I got a response
12 back but the response I got back I saw as -- I don't
13 know. They didn't answer any of my questions. Like,
14 I'd say, "Oh" -- I'd put something across and the answer
15 I'd get back is, "Is this a question Samantha wants
16 answered?", or something like that but nothing would
17 actually get answered because I didn't put it in the
18 correct terminology. I'd just say, like, "I'm really
19 upset with this, and how come this is ..."

20 Yeah, so ...

21 **Q.** I just want to try to --

22 **A.** Yeah, sorry.

23 **Q.** No, no, please don't apologise. You haven't done
24 anything wrong. I just want to probe a little bit more
25 about that.

1 **A.** Yeah.

2 **Q.** So let's just start at the beginning of the After Action
3 Report. Were you told that one was going to be done?

4 **A.** No.

5 **Q.** Okay. Whilst that investigation was taking place, were
6 you spoken to about it?

7 **A.** A little bit by the family liaison officer, I think,
8 from what I can remember.

9 **Q.** When they spoke to you about it, whilst it was ongoing,
10 why were they speaking to you? What were they speaking
11 to you about?

12 **A.** Well, I just said -- this was when I was saying that
13 I wanted to know what had happened, and she's like, "I'm
14 sure" -- I didn't know that that was specifically --
15 I didn't know that was the report. I just got told
16 there'd be a follow-up, like, saying about Paula's care.

17 **Q.** Okay. Let's see if we can have up, please, page 12,
18 paragraph 69, 70 and 71. Here you set out sections of
19 the report. So this was a report that was sent to you,
20 was it?

21 **A.** Yes.

22 **Q.** Okay. You say here, you've quoted some parts of the
23 report. This is paragraph 69:
24 "The group struggled to identify any formal actions
25 to take following the AAR [the After Action Review]. It

1 was felt that reflection of the positive practices of
2 the teams should be considered and that other teams
3 should reflect on their practice with complex clients,
4 further stating that learning would be shared widely
5 throughout the Trust by 'risk management to share
6 learning with community teams across the Trust'."

7 Then at paragraph 70, you go on to say that:

8 "It was identified that the team were responding to
9 [Paula's] fluctuations in mental state appropriately and
10 providing levels of support that were reasonable to the
11 level of risk period. It was difficult to identify
12 learning as the team had followed policy, procedure and
13 beyond. Attempts were made by the team to predict
14 difficulties around medication and how to support
15 [Paula] with this during difficult periods and
16 increasing the level of support as required.

17 "One thing that was taken away from the [After
18 Action Review] meeting was that the team did in fact
19 support [Paula] to the best of their abilities and
20 worked well as a team to manage numerous long-term
21 risk."

22 Then before we come on to paragraph 71, I just want
23 to ask you about the meeting, the After Action Review
24 meeting. Were you invited to attend a meeting?

25 **A.** I can remember having a meeting but I don't know if

1 I was so much -- I mean, obviously I was invited to it,
2 but I kept saying to my family liaison officer about it,
3 and then about having a meeting about it, because I said
4 there's questions I need answers to. This isn't -- this
5 doesn't sum up -- this to me, it is completely -- it
6 could be wrote about somebody else. It doesn't sound
7 like my sister's care. So then I was invited to
8 a meeting but I don't know whether I'd have been invited
9 to that if ...

10 **Q.** Okay. So there was a meeting afterwards that you do
11 recall attending?

12 **A.** Yeah.

13 **Q.** It was done after the report was done?

14 **A.** Yeah, like a Zoom meeting.

15 **Q.** Okay. Just explain to us, if you can, please, Sam, what
16 was the response of those individuals who you were
17 saying, "This doesn't represent Paula's care"?

18 **A.** I just got told that it was pretty much a reading of
19 this, pretty much the statement, because I didn't have
20 the medical records because I couldn't get her medical
21 records because they were leading me round and round in
22 circles to get them, I couldn't specifically say -- when
23 you're in that much grief, after you've just found
24 somebody you love, trying to then jump through all these
25 hoops and twists and turns and everything to try to find

1 answers, and then you're just being fobbed off, it's so
2 difficult because then you just get to how Paula felt,
3 where I just feel -- feel defeated.

4 **THE CHAIR:** Can I be absolutely clear. At no point before
5 this report had anybody -- I'll phrase that differently.

6 Had anybody, at any point before this report was put
7 to you and you saw it, asked you for your views?

8 **A.** No. Nobody. I wasn't getting asked anything. I was
9 expressing to my -- that's the only person I had contact
10 with, was the family liaison officer -- I kept saying,
11 "I want answers", and I said to her, I remember one
12 point, I said, "I'm going to fight this", and she turned
13 round to me and said, "There's no point; you're not
14 going to get anywhere".

15 **THE CHAIR:** Thank you.

16 **MS MALHOTRA:** I think, if we have a look at paragraph 71 at
17 the bottom of page 12, you say:

18 "They also proudly cover what they say went well in
19 relation to Paula's care ..."

20 Then if we go to page 13, at the top of page 13:

21 "Care co-ordinator had been in place for last six
22 weeks, following [Paula's] request to change which the
23 team facilitated.

24 "The team reacted to her needs as they came up,
25 changed care co-ordinator, organised urgent medication

1 reviews, provided duty input and weekend support and
2 [Paula] engaged well with the support."

3 Then it goes on to talk about the shock and surprise
4 of Paula's death.

5 So that's her care in the community, it would seem.
6 Would you agree with that?

7 **A.** No. Even down to this -- where did I just see this?

8 Oh, yeah:

9 "Was being monitored face to face every two weeks
10 for the depot, this gave time for care co-ordinator to
11 engage and would spend around 60 minutes at each
12 appointment to allow [Paula] time and space to explore
13 her difficulties."

14 I think I mentioned earlier, they were in and out.

15 **Q.** Just so everybody who's following this can see, this is
16 the third bullet point on page 13. I'm not sure if we
17 can highlight that. Thank you. So this was when she
18 was meeting for her depot injections --

19 **A.** Yeah.

20 **Q.** -- in the community.

21 **A.** *(Witness nodded)*

22 **Q.** You described earlier, I hope I've fairly summarised
23 your evidence in this way: that she would have her
24 injection, there would be a couple of minutes of
25 conversation --

1 **A.** Yeah.

2 **Q.** -- and then she would leave?

3 **A.** *(Witness nodded)*.

4 **Q.** And pre-Covid it was different?

5 **A.** Yeah, it was.

6 **Q.** But your understanding of Paula's experience at that
7 time was that it was a very brief interaction?

8 **A.** Yeah.

9 **Q.** Is that a fair summary?

10 **A.** That's fair, yeah.

11 **Q.** So where it refers here to Paula spending around 60
12 minutes at each appointment, to allow her time and space
13 to explore her difficulties, did you recognise that at
14 all?

15 **A.** Sorry, can you --

16 **Q.** Do you recognise the 60-minute appointment that she
17 would have had?

18 **A.** Not -- she used to have that but she hadn't had that for
19 a long time.

20 **Q.** Is it possible that she was having these appointments
21 but you weren't aware of it?

22 **A.** She'd told me. She kept saying that she wants to talk
23 to somebody. She got, like I explained, lonely during
24 Covid because she was isolated, and her care got cut
25 back more and more. And she'd explained to me that her

1 care was getting cut back more and more and more. And
2 then, when I brought that up, it was -- I got told it
3 wasn't. But, again, for her -- if I could have had
4 medical records or something, or maybe know myself. But
5 she wouldn't lie about that. She'd tell me straight
6 after. I spoke to her all the time on the phone. Like
7 always on the phone with her. And she'd get really
8 upset that she just -- about her care being cut back.

9 **Q.** Just so we can put into context, please, you outline
10 your concerns. So this is over on page 14. At the top
11 of page 14 you say:

12 "To pick out a few of the concerns with the report
13 ..."

14 Then you go on to say at paragraph 77 that this was
15 "misleading", and this was in regard to the 60 minutes
16 that you've mentioned.

17 **A.** Yeah.

18 **Q.** You say here that Paula complained to you multiple times
19 that she was not having face-to-face meetings with her
20 social worker, as often as she needed to.

21 **A.** Yeah.

22 **Q.** So that's one aspect.

23 Then, if we go on to paragraph 79 -- sorry, I don't
24 mean to skip over it, but 78 --

25 **A.** I think I mentioned that earlier.

1 Q. -- you mentioned it earlier, about the trainees being
2 brought?

3 A. Yeah.

4 Q. Was there anything else you wanted to say about that?

5 A. No.

6 Q. Then at paragraph 79, the report talks about concern of
7 the care co-ordinator and that Paula was higher risk of
8 overdose or misadventure. It then talks about how she
9 died and their surprise and with regards to that.

10 A. See, that shocks me because, if anybody had seen her
11 within the months previous, they'd have known that that
12 particular method was the only method she was talking
13 about. Although she did take a couple of overdoses, the
14 way she did end her life was exactly how she'd been
15 saying for the months leading up, whereas if they were
16 there talking to her about all this beforehand, then it
17 wouldn't have come as such a shock.

18 Q. I just want to understand, in terms of the chronology,
19 because we know that you received a letter from Patient
20 Safety, I think it was 15 March. Let me just double
21 check the date. Yes, 15 March 2022. That's at
22 paragraph 72, page 13 of your statement.

23 With regards to your concerns that you raised, were
24 those concerns that you raised in writing?

25 A. In an email.

1 Q. In an email?

2 A. Yeah.

3 Q. Following the meeting that you had after the report was
4 prepared?

5 A. Um --

6 Q. The Zoom meeting?

7 A. Sorry, I can't remember. Sorry.

8 Q. Okay. Just tell us, please, as a result of the Zoom
9 meeting that you attended, the concerns that you had,
10 that you expressed in an email, how did you feel that
11 your concerns were being dealt with?

12 A. They weren't. I got -- didn't get any answers. I got
13 what felt like sarcastic, condescending comments to each
14 question but no answers. It was like, "Okay, so is this
15 something Samantha wants an answer to?"

16 Well, yeah, that's why I'm mentioning it.

17 I think I've got -- yeah, so I wouldn't -- the way
18 I wrote my email, I don't think I structured it in the
19 correct way. Like, my questions weren't -- I should
20 have been more precise of what I wanted answering and
21 I think they saw a little loophole so they wouldn't
22 answer the way that -- yeah. Sorry.

23 Q. I want to take you to page 15, if I may, and
24 paragraph 86.

25 A. Yeah.

1 Q. You say here that you sent to the coroner's office, on
2 21 October 2022, your concerns. I just wondered whether
3 that helps jog your memory --

4 A. Yeah, thank you.

5 Q. -- at all of the chronology?

6 A. Yeah.

7 Q. So does that help you --

8 A. Yeah. Yeah, so obviously I sent the -- I sent the email
9 after the report findings but, as I mentioned, there
10 wasn't any clear answers to any of my questions.

11 Q. So it was an email of concerns that you sent to the
12 coroner's office but you also sent to EPUT, as well, did
13 you, or was it just to the coroner's office?

14 A. I think -- I'm not 100 per cent sure, sorry. I know
15 that my -- I -- no, sorry.

16 Q. If we turn over the page, then, at page 16, we can see
17 there listed (a) to (g), and it goes over on to
18 page 17 -- and I wonder if we could have that on the
19 screen, please. So it's page 16. It does go over to
20 the next page, but just looking at page 16, these are
21 the concerns that you raised, were they?

22 A. Yeah.

23 Q. Is there anything that I haven't asked you that you
24 wanted to speak about with regards to those concerns?

25 A. Mm --

1 Q. Just take your time.

2 A. Okay. Um, no. There is the one when she was left in
3 hospital without her medication. They weren't giving
4 her any of her medication. So that was one. I'd
5 forgotten about that. That's when she had her fractured
6 back. So she had that while she was in the hospital for
7 the three days, and there's just another question of why
8 didn't she have her medication? Because if she didn't
9 have any medication -- she said she was allowed
10 paracetamol for her broken back but she wasn't having
11 anything else and -- like, her BPD medication, or
12 anything like that. And that also makes me think, when
13 they come to discharge her, after those three days that
14 she was kept in -- obviously, I don't know what she said
15 but why was her medication kept away from her at that
16 time? Just none of -- just, again, it just shows how
17 poor her care was.

18 Q. So just to orientate us in time, this was some time
19 between November and December --

20 A. That was in November --

21 Q. -- 2021.

22 A. Yes.

23 Q. So there were three days she was in hospital with her
24 back?

25 A. Yeah. She claimed she wasn't given any of her

1 medication.

2 **Q.** Do you know what hospital she was at?

3 **A.** Broomfield.

4 **Q.** What I'd like to do next is to turn to recommendations
5 but, before I do that, is there anything else about the
6 investigation that you wanted to raise that I haven't
7 asked you about?

8 **A.** No.

9 **Q.** Okay. And so I'll ask if we could have, please, page 17
10 of your statement, paragraph 88. This is the section
11 that deals with your recommendations for change that
12 you'd invite the Chair to consider. It goes over the
13 page on to page 18, as well, at (b) and (c) on that
14 page. Just looking at page 17, paragraph 88(a), you've
15 listed there interdisciplinary communication. Do you
16 want to expand upon that recommendation and why you
17 invite the Chair to consider it?

18 **A.** So, yeah, myself and my sister and family friends would
19 always be calling the doctors and Paula's social care,
20 and people, but it's like there was no communication in
21 between different -- in between different care
22 facilities. So nobody ever knew what we was talking
23 about. There needs to be, like, more communication, if
24 you're going to be dealing with somebody's care.

25 **Q.** So that's care with families, discussions --

1 **A.** Yeah.

2 **Q.** -- and involving family in those decisions?

3 **A.** Yeah.

4 **Q.** But also it sounds to me that you're talking about
5 between facilities?

6 **A.** Yeah.

7 **Q.** So between the community care and between the hospitals?

8 **A.** Yeah.

9 **Q.** Is that right?

10 **A.** Yeah. But also, it's like you mentioned earlier when
11 you said, "Oh, did anybody call you to mention she was
12 being discharged and how was it" -- nobody calls.
13 Nobody asked. You know, for all they know, Paula could
14 have been -- she could have asked to just come out and
15 I do think there needs to be more communication from
16 family and stuff. Sorry.

17 **Q.** Turning over the page, then, to page 18. At the top of
18 that page, you say, "Scarcity of inpatient beds". Do
19 you just want to explain why you invite the Chair to
20 consider that recommendation?

21 **A.** Well, every time we'd go to hospital, we was getting
22 told, "There's no beds, there's no beds". She -- Paula
23 did die waiting for a bed. She was told every time we
24 went there that there's no beds, there's nowhere for her
25 to go. And that just led to her being sent home. Needs

1 to be more beds for -- otherwise, it's just going to
2 keep happening again and again and people keep getting
3 sent home.

4 **Q.** At (c) you say, "The need for proper mental health
5 assessments". Just explain what you mean by that,
6 please?

7 **A.** Sorry, I'm just refreshing my memory.

8 **Q.** That's okay. Just take your time.

9 **A.** Yeah, so with -- there needs to be proper mental health
10 assessments because my sister was sent home, as far as
11 I'm concerned, still being a risk to herself. If they'd
12 have done a proper assessment after she kept saying how
13 she wanted to take her life, then surely she shouldn't
14 have been sent home. As far as I'm concerned, she got
15 sent home to die.

16 **MS MALHOTRA:** Thank you, Sam. I have no further questions
17 for you.

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

19 **Questions from THE CHAIR**

20 **THE CHAIR:** Yes, I'm just a little bit confused about this
21 time when she was in the mental health liaison suite.

22 **A.** Yeah.

23 **THE CHAIR:** She'd gone to A&E, those three days. Had she
24 gone for her back or had she gone because she wanted to
25 see somebody about her mental health?

1 **A.** That was only about her mental health.

2 **THE CHAIR:** That was only about her mental health?

3 **A.** Yeah.

4 **THE CHAIR:** When was it that she went about her back?

5 **A.** So when she went about her back, that was before then,
6 but I don't really know because I didn't really take her
7 for that.

8 **THE CHAIR:** Right, but it was sometime earlier in November,
9 you think?

10 **A.** Yeah, yeah but I think she'd -- she'd got really
11 stressed out, kicked a door and fractured her back, so
12 ...

13 **THE CHAIR:** Yes, I understand.

14 **A.** But yeah, when I took her it was simply for her mental
15 health.

16 **THE CHAIR:** Thank you. That's all I wanted to know.

17 **MS MALHOTRA:** Thank you very much.

18 Well, Chair, we have three photographs that you have
19 kindly provided that we're going to now see of Paula so
20 I'll ask that those photographs be put on the screen,
21 please, now.

22 *(Photographs displayed)*

23 Thank you very much for sharing those photographs
24 with us. We're now going to take a ten-minute break to
25 see if there are any questions --

1 **THE WITNESS:** Okay.

2 **MS MALHOTRA:** -- from anybody for you. If there aren't any
3 questions, that concludes your evidence and can I thank
4 you in advance for giving your evidence to the Inquiry
5 and for your witness statement as well that you've
6 provided.

7 So if there aren't any questions, that concludes
8 your evidence to this Inquiry. If there are, we will
9 come back.

10 Chair, if there aren't any questions, I believe we
11 will be resuming at 2.00.

12 **THE WITNESS:** Thank you.

13 **THE CHAIR:** Thank you very much indeed, from me. I'm very
14 grateful for your evidence.

15 **THE WITNESS:** Thank you.

16 **THE CHAIR:** We will sit again at 2.00 if there are no
17 questions.

18 **(12.05 pm)**

19 **(The short adjournment)**

20 **(2.00 pm)**

21 **THE CHAIR:** Thank you, Ms Lloyd-Owen.

22 **MS LLOYD-OWEN:** Good afternoon, Chair, we will now hear
23 evidence from Karen Michel in relation to her sister
24 Marion Michel.

25 **KAREN MICHEL (affirmed)**

1 **Questioned by MS LLOYD-OWEN**

2 **MS LLOYD-OWEN:** Thank you. Please can you state your full
3 name for the record?

4 **A.** Yes, Karen Anne Michel.

5 **Q.** You are the sister of Marion Michel, who was born on
6 5 August 1965 and died on 4 March 2022 at the age of 56;
7 is that right?

8 **A.** Yeah.

9 **Q.** I understand that you would like me to refer to Marion
10 by her first name --

11 **A.** Yes.

12 **Q.** -- throughout my questions and you would like me to call
13 you Karen; is that right?

14 **A.** Yes, please.

15 **Q.** By way of background, the Inquiry sent a request for
16 evidence to you under Rule 9 of the Inquiry Rules on
17 10 February 2025 and, in response to that request,
18 you've prepared a witness statement to the Inquiry. Do
19 you have a copy of that statement in front of you?

20 **A.** Yes, I do, yeah.

21 **Q.** It is dated 24 June 2025. If you can turn to page 64 of
22 that statement, that's almost at the back.

23 **A.** Yeah.

24 **Q.** Is it right that you made a statement of truth and then
25 signed your witness statement?

1 **A.** Yes, that's correct.

2 **Q.** Have you had an opportunity to read that statement
3 through recently?

4 **A.** Yes.

5 **Q.** I understand there is one correction you wish to make in
6 relation to paragraph 90 of the statement.

7 **A.** Yes, that's correct.

8 **Q.** And that is where it says that there was "no ward
9 psychologist in post (a gap of 11 months)". This
10 should, in fact, say eight months; is that right?

11 **A.** That's correct.

12 **Q.** Aside from that correction, is that document true and
13 accurate to the best of your knowledge and belief?

14 **A.** Yes, it is.

15 **Q.** Thank you. As you know, the witness statement will
16 therefore stand as your evidence to the Inquiry but I'm
17 going to ask you some questions about that statement,
18 and please be assured that the Chair and Inquiry team
19 have read and considered everything you say in your
20 statement very carefully and it will form part of the
21 body of evidence on which the Inquiry will rely.

22 **A.** Yeah.

23 **Q.** I would also just like to acknowledge that you've
24 provided a commemorative and impact statement in
25 relation to your sister Marion, and the Inquiry is

1 extremely grateful for both that account and also the
2 evidence you're giving today.

3 **A.** Yeah.

4 **Q.** Marion was not under the care of Essex Mental Health
5 Services until the end of 2018 when she was 53 years
6 old; is that correct?

7 **A.** Yes, that's correct.

8 **Q.** What I want to start doing with you is start by going
9 through some earlier details of Marion's mental health,
10 because of its relevance to her presentation and the
11 assessments made of her risk when she was later being
12 cared for in Essex.

13 **A.** Yeah.

14 **Q.** Marion, I understand, first had contact with mental
15 health services in Jersey in 1984 when she was 19 years
16 old?

17 **A.** Yes, that's correct.

18 **Q.** Then some years later in 1998 she was diagnosed with
19 paranoid schizophrenia?

20 **A.** Yes, that's correct.

21 **Q.** In your statement you set out a number of serious
22 incidents that happened between 1999 and 2003, including
23 an incident in 1999 when Marion stabbed her then partner
24 with a large kitchen knife when he was asleep; is that
25 right?

1 **A.** Yes.

2 **Q.** An incident in 2002, in which Marion stabbed herself in
3 the chest and abdomen, using a kitchen knife and, when
4 the emergency services arrived, jumped off the balcony
5 of her flat, and a further incident in 2003 when Marion
6 jumped out of the window of her flat?

7 **A.** Yes.

8 **Q.** Thereafter, is it right that Marion continued to be
9 under the care of mental health services in Jersey until
10 2010?

11 **A.** Yeah, that's correct, yeah, she had the same
12 psychiatrist for a number of years that she had a very
13 good relationship with and when he retired shortly after
14 that, he was transferred back to her GP because she was
15 quite stable at that time.

16 **Q.** She'd been on the same medication for a period of time;
17 is that right?

18 **A.** Yeah.

19 **Q.** Moving forward some years, then, in 2018, Marion stabbed
20 her then partner and was remanded in custody at La Moye
21 prison in Jersey; is that right?

22 **A.** Yes, that's correct.

23 **Q.** Then whilst Marion was remanded in custody at La Moye
24 prison, she cut her neck, wrists and feet with a sharp
25 item in her cell, and these injuries required emergency

1 surgery and intensive care treatment at Jersey General
2 Hospital?

3 **A.** Yes.

4 **Q.** It was then, following that treatment, that Marion was
5 transferred from Jersey to Fuji Ward at Brockfield House
6 in Essex?

7 **A.** Yes, it was the news that she was going to transfer that
8 caused her to do that because she said that she didn't
9 know where she was going and she was scared. And then,
10 after that, she was, you know, discharged back to prison
11 and then she was transferred again on 20 December --

12 **Q.** Thank you.

13 **A.** -- which went without incident, this time.

14 **Q.** So once she's back in La Moye prison in Jersey, she's
15 then transferred all the way to Essex --

16 **A.** Yeah.

17 **Q.** -- for the first time, is this right, that her care,
18 mental health care, was not happening on the island of
19 Jersey?

20 **A.** Yeah.

21 **Q.** Was this because this had been identified, Brockfield
22 House, as an appropriate, specialist, forensic secure
23 facility --

24 **A.** Yes.

25 **Q.** -- and there wasn't that option available on the island

1 of Jersey?

2 **A.** Yeah, there's nothing like that there, no.

3 **Q.** I want to just clarify a few points now about Marion's
4 status while she was at Brockfield House from
5 20 December 2018. She was transferred initially for
6 a 12-week inpatient assessment at the unit under the
7 Mental Health Act; is that right?

8 **A.** Yes, and that was as part of court proceedings, yeah.

9 **Q.** Yes. That's then extended and then, when the court
10 proceedings finish on 16 December 2019, she is --
11 remains at Brockfield House, this time under
12 a Section 37 hospital order --

13 **A.** Yes.

14 **Q.** -- with Section 41 restrictions?

15 **A.** Yes, that's correct.

16 **Q.** So it's from 20 December 2018, when Marion is under the
17 care of the Essex Partnership University NHS Foundation
18 Trust, which we'll be calling EPUT, and she remains
19 under EPUT's care until her tragic death on 4 March 2022
20 as a result of multiple self-inflicted stab wounds; is
21 that right?

22 **A.** That's correct.

23 **Q.** I want to focus now on what happened at Brockfield
24 House --

25 **A.** Yeah.

1 Q. -- but to initially ask you some questions about
2 Marion's diagnosis and risk profile, as it was
3 understood by those treating her at Brockfield House.
4 So whilst she's at Brockfield House, Marion is assessed
5 by Dr B; is that correct?

6 A. Yes, that's correct.

7 Q. Who did you understand him to be; what was his role?

8 A. He was the consultant forensic psychiatrist and he was
9 the lead clinician, I think they're called, for the
10 multidisciplinary team, so for her ward. I think there
11 were different psychiatrists responsible for different
12 wards within Brockfield House, and he was the lead
13 clinician for her and he'd been involved in the court
14 proceedings assessing her in that as well.

15 Q. Once the Section 37 hospital order is put in place, did
16 you understand him to be the responsible clinician?

17 A. Yes, he was, yeah.

18 Q. So, effectively, he was there providing a report every
19 six months; is this right?

20 A. Yeah, to the Jersey courts, yes.

21 Q. He assesses Marion when she first arrives at Brockfield
22 House and is it right that she also underwent a full
23 psychological examination by a senior psychologist for
24 Fuji Ward, who we'll be referring to as Ms C?

25 A. Yes, that's correct.

1 Q. What involvement, if any, did you have with these
2 assessments?

3 A. I spoke to the forensic psychologist at length. She
4 arranged a call with me. I didn't speak to the
5 psychiatrist or any other people in that team.

6 Q. You explained in your statement that Marion's final
7 diagnosis, which was agreed by Dr B and Ms C, was that,
8 alongside schizophrenia, which was in remission, Marion
9 exhibited traits of emotionally unstable personality
10 disorder, of both impulsive and borderline types,
11 although these did not amount to full disorder; is that
12 correct?

13 A. Yeah, they were seen as traits of them and it was
14 paranoid schizophrenia, I think, which had been in
15 remission for some time before she -- he agreed that it
16 had been in remission and controlled by medication for
17 some time before she went to Brockfield House.

18 Q. Is it right, though, that whilst there was that
19 agreement on that final diagnosis, that there initially
20 had been some disagreement between Dr B and Ms C
21 regarding whether Marion was psychotic at the time of
22 stabbing her ex-partner in 2018?

23 A. Yes, at first I think Ms C, the psychologist, thought
24 that Marion -- because of her lack of problem --
25 difficulties with problem solving and part of the

1 emotionally unstable personality disorder traits, had
2 got so stressed that that had tipped her into psychosis
3 very quickly. So it was for this phrase that kept being
4 used, as a quick relapse to psychosis. They both agreed
5 that in 1999 in the incident where she stabbed her then
6 partner that she had been psychotic, and I saw her and
7 she was psychotic.

8 **Q.** Yes.

9 **A.** But in 2018, the psychiatrist thought that this was more
10 to do with the emotionally unstable personality disorder
11 traits, and stress, but he didn't think she was
12 psychotic. He didn't think there was any evidence that
13 she became psychotic. So they disagreed about that but,
14 in the end, the psychologist did agree, towards the end
15 of proceedings, that Dr B was -- that was correct and
16 she sort of acquiesced to his view.

17 **THE CHAIR:** That's Ms C did?

18 **A.** Yes.

19 **THE CHAIR:** Thank you.

20 **MS LLOYD-OWEN:** So, ultimately, some months later, the close
21 of the criminal proceedings, the final diagnosis is
22 agreed between them and there's a joint understanding,
23 originally Dr B's, and then joint --

24 **A.** Mm.

25 **Q.** -- that Marion was not psychotic --

1 **A.** Yeah.

2 **Q.** -- in 2018?

3 **A.** But that's not what the reports that still existed said.

4 **Q.** Yes.

5 **A.** That was something that happened in court.

6 **Q.** Can you tell us a little bit about, despite this
7 agreement, your understanding that there was some
8 confusion from those staff treating Marion over this
9 period at Brockfield House as to what to expect if she
10 were to relapse?

11 **A.** Yeah, well, there was a -- I think when I -- because
12 I didn't know any of this before Marion died and having
13 access to the inquest bundle, but I just kept reading
14 the discrepancy, and I thought -- and I saw, like, in,
15 you know, things that nurses had written, that they
16 would cut and paste this "quick relapse to psychosis",
17 and the second psychologist she had -- I can't remember
18 what he's referred to --

19 **Q.** Mr D.

20 **A.** -- Mr D -- he, in his statement to the inquest, actually
21 said that she was psychotic. It was commonly agreed by
22 the multidisciplinary team that she was psychotic in
23 2018. So it just -- and the investigators that did the
24 investigative report after she died also referred to
25 this. So it was very -- I picked it up; they didn't

1 pick it up. It just seemed to be very confusing and
2 I thought, well, how did the staff know whether, you
3 know, Marion being unwell was going to look like her
4 being psychotic or look like nothing was happening?
5 And, in fact, on the day she died, according to evidence
6 that -- the staff there that day, one said she'd
7 expected her to be psychotic and aggressive and the
8 other one said she expected her to be quiet.

9 So it was really a bit of a mess and quite
10 concerning that, you know, someone in this specialist
11 resource, where there'd been a disagreement in the court
12 process, I think the staff had then used -- because the
13 original psychologist was brilliant, she was excellent,
14 and they had probably had access to her report maybe
15 more than they had because it was a psychological
16 assessment; it wasn't a report written for court.

17 So maybe they had access to her report, and they
18 didn't have access to Dr [redacted] -- sorry, Dr B --
19 and he didn't ever seem to actually put that right,
20 throughout the whole time. And he was one of the people
21 that had known Marion from before she even went to
22 Brockfield House. So he had known her the longest, he
23 had been there through the court process but he never
24 seemed to correct this misunderstanding about how -- you
25 know, what the cause was from the 2018 incident.

1 **THE CHAIR:** But if he had not exactly prevailed, his
2 diagnosis had not been evident to the staff because of
3 this confusion. The issue, I think, is whether she
4 might have appeared as psychotic at the time of being
5 unwell or doing things that were --

6 **A.** Mm, mm.

7 **THE CHAIR:** -- as a sign to look out for.

8 **A.** Yeah.

9 **THE CHAIR:** But if he had not corrected that, then they
10 wouldn't be looking for that sign of psychosis.

11 **A.** I think there was confusion because he was saying that
12 she wasn't psychotic and the psychologist was saying
13 that she was: she had tipped into psychosis through
14 stress. So it was a confusing picture.

15 **MS LLOYD-OWEN:** I think you say in your statement that,
16 although there was this ultimately agreed position and
17 final diagnosis --

18 **A.** Mm.

19 **Q.** -- that you consider that information about the nature
20 of Marion's past relapses was not effectively relayed to
21 staff?

22 **A.** No, I don't think it was.

23 **Q.** Would Dr B have been somebody, as you understand it, who
24 was part of that multidisciplinary team?

25 **A.** Well, he was the head of that team which met every two

1 weeks at ward rounds, so it really should have been his
2 job and especially once Ms C left, which was in
3 September 2020, because then she wasn't there to say,
4 "Well, actually, that's wrong".

5 **Q.** Yes.

6 **A.** You know, he would have been the only person involved in
7 those court proceedings that knew that that sort of went
8 on. And I'm sure that must happen in a lot of court
9 proceedings where experts don't agree and, obviously,
10 and everyone Brockfield House has been through some
11 court process to get there.

12 **Q.** So would you say that this is something where better
13 record-keeping or indeed greater work from Dr B to
14 correct the position should have happened?

15 **A.** It should have happened and it also showed in the
16 investigation report because they didn't even mention
17 what Marion's diagnosis was, really, especially the
18 emotionally unstable personality disorder traits.

19 **Q.** You also mentioned that this may have impacted on
20 Marion's own understanding of her mental health and past
21 harmful actions --

22 **A.** Mm.

23 **Q.** -- if the staff treating her were not clear; is that
24 right?

25 **A.** I think it probably did. I think it probably did.

1 Q. I want to come now to ask you about your knowledge of
2 the physical environment of Brockfield House but, before
3 I do, just to remind you not to mention any staff names.

4 A. Sorry, sorry.

5 Q. Not to worry. I will try and refer by role to assist as
6 well.

7 A. Yeah.

8 Q. I want to ask you about your knowledge of the physical
9 environment at Brockfield House. So Marion first
10 arrived on 20 December 2018. At that stage, how often
11 were you able to visit her at that ward, Fuji Ward?

12 A. I think the issue was my distance. I was a two-hour --
13 almost a two-hour drive away, and I could go for an
14 hour. So I think I was trying to go sort of once
15 a fortnight on a Saturday. Sometimes there were longer
16 gaps but generally I was trying to go once a fortnight.
17 So it started for an hour visit, actually, on Fuji Ward.

18 Q. What was your impression of the building itself, the
19 facilities?

20 A. It was very positive because it was built for purpose.
21 I think the 10-year anniversary of something of it being
22 built was when Marion was there. So it was quite an
23 impressive building and, as I say, it had been built for
24 that purpose: to be a forensic secure unit. So a lot of
25 thought had gone into the design and it was, you know,

1 it was relatively new, and the, you know, the staff on
2 reception -- the reception area was nice, very
3 welcoming. And there was a room specifically for
4 visitors on the ward and there was visitor toilets and
5 so it was quite good, you know, well thought out, and
6 there was an airlock to go into it, as you'd expect
7 because, obviously, people weren't allowed out -- or
8 Marion wasn't allowed out at that stage.

9 **Q.** Then turning to Fuji Ward in particular, can you
10 describe for us what Fuji Ward was like when you visited
11 it? What your impression was of the ward?

12 **A.** Yeah, I mean, it was quite a nice environment.
13 Obviously, you know, there weren't chairs that you could
14 pick up and throw. It was all designed, sort of inbuilt
15 stuff. We went into the dining room sometimes if there
16 was another visitor, and that was quite nice. There was
17 a garden area. The sort of bedrooms went off two
18 corridors. I didn't see Marion's bedroom but, yeah, as
19 I say, it was sort of well-kept. Marion used the garden
20 a lot in the summer. And there was activities on the
21 ward. I think there was a sensory room which the women
22 there had helped to set up with staff. So yeah.

23 **Q.** And in terms of your observations of how staff were
24 interacting with patients during your visitors to Fuji
25 Ward, what was your impression of the relationships with

1 staff on Fuji Ward?

2 **A.** Well, I didn't sort of see that many -- I did see staff
3 around, and coming and going, because the visitor room
4 was right at the entrance to the ward, so if I was
5 there, they'd be coming and going and taking people to
6 different places. And they were always very friendly.
7 Marion had, you know, some good relationships with staff
8 there. I think one was going to Jersey so Marion had
9 been sort of telling her where to go, and so yeah.
10 I think, you know, from what I could tell when I went
11 there it was fine. And sometimes, when Marion was
12 allowed to have perimeter leave, ground leave, in the
13 grounds, I met staff there, like her key worker who
14 seemed very nice and I know Marion thought highly of
15 her.

16 **Q.** In terms of -- and you may not be able to comment on
17 this, but did it seem to you that patients were listened
18 to and engaged with by staff, from what Marion told you
19 or what you observed?

20 **A.** Yeah, I think -- I don't know all the details but
21 I think the room I sat in had like, "You said, we did",
22 you know, on the wall.

23 **Q.** Yes.

24 **A.** And I think you could see that some things had been
25 listened to and, because women were there for years on

1 this ward, so it wasn't like someone was going to come
2 up with an idea and then go away again. They were going
3 to still be there saying the same thing, you know, in
4 months' time. So I think they generally did have to
5 work with people and I think mobile phones might have
6 been one of those things which did happen whilst Marion
7 was there and I can't remember if it was because of
8 Covid or not but it sort of transitioned from having to
9 phone, a ward phone, in the middle of the ward, you
10 know, like a pay phone, to actually people having their
11 own mobile phone, which was obviously much better.

12 **Q.** In terms of the activities, you've touched upon there
13 being a sensory room. What activities were there
14 available to Marion whilst she was on the ward?

15 **A.** On Fuji Ward there was a lot -- the occupational therapy
16 service had a lot of different activities. They did
17 cooking. They did, you know, education. There was
18 a whole education thing where you could do different
19 qualifications, which Marion did. There was Ladies'
20 Morning, I think it was called, and book clubs and, you
21 know, going to the gym or doing exercise. So on Fuji
22 Ward, because a lot of women there couldn't go out,
23 there was a lot of things based on that ward or within
24 the wider building.

25 **Q.** I want to ask you now what your impression was of

1 whether Fuji Ward was safe and whether Marion felt safe
2 there. What was your sense as to whether this was
3 a safe place?

4 **A.** I think when she first went there it was quite settled.
5 I think a lot of the women had been there for quite
6 a long time, so there was quite a settled group. That
7 was the impression I got. And then I think, you know,
8 during sort of the start of Covid and things, that sort
9 of did, or sort of as time went on, that did change as
10 people were discharged or moved to other wards. There
11 was a lot more very unwell women there, and some of the
12 more stable women relapsed, and, you know, were very
13 unwell.

14 So I think then it didn't feel so safe. But Marion
15 had the key to her room so she just knew to make herself
16 scarce. But also -- what was I going to say? I can't
17 remember. Sorry.

18 **Q.** Don't worry. Was it your impression that the times of
19 perhaps Marion feeling unsafe or a new patient coming
20 onto the ward, were the sort of inevitable consequences
21 of this kind of facility, but that staff were taking it
22 seriously and dealing with it well, or that there were
23 problems in the way it was being handled?

24 **A.** No, I think, from what I recall, you know, staff did
25 deal with incidents. But I think there was a knock-on

1 effect on the staff themselves because I think also
2 a lot of staff -- there was a bit of a churn of some
3 staff moving, agency -- because it was six. There
4 should have been six staff, I think, for 12 women on
5 that ward.

6 **Q.** I see.

7 **A.** But that was because some people sometimes needed
8 one-to-one observation, you know, 24/7 or even
9 two-to-one observation. So that would then take up
10 staff and, if they were short of staff, that impacted on
11 the women that were more stable because they couldn't be
12 taken out to the grounds, they couldn't be taken up to
13 a room to do something else because there just simply
14 wasn't the staff.

15 And that became quite limiting for Marion because
16 she was quite stable, that, you know, as time went on,
17 she was being quite restricted by the fact that she was
18 on this assessment ward because of the needs of other
19 women. That's just -- was kind of the nature of the
20 ward. But I know there were times when -- she said to
21 me, like, they can't get any agency staff to work on
22 this ward because I think people -- you know, staff were
23 being assaulted. So I guess word spreads, doesn't it?
24 You know, I guess it's the kind of who you -- you know,
25 how much choice places have to choose who they're going

1 to take in, especially during Covid, and they're taking
2 women from prison.

3 Q. Yes.

4 A. I don't know what, you know, what choices they had or
5 whether they just had to take people.

6 Q. I think you say in your statement that anecdotally there
7 seemed to be more sickness absence at these times --

8 A. Yeah.

9 Q. -- when there were particularly -- I think you describe
10 them as challenging or aggressive patients; is that
11 right?

12 A. Yeah, I do remember one staff member who actually --
13 Marion couldn't go out, she was sort of building up to
14 going into the community on her own and you need to do
15 a certain amount of escorted trips out.

16 Q. Yes.

17 A. And this one staff member, actually, did offer to use,
18 when she normally went for a walk in her break, she
19 said, "I'll take Marion" and she took her for this, you
20 know, what should have been her break. So some staff
21 did go above and beyond but, you know, that -- most of
22 the time things got cancelled. But, as I say, that
23 changed throughout the time Marion was there and
24 obviously, when Marion was first there, she didn't have
25 any leave, so it's a changing picture.

1 Q. I think you also explain that Marion was asked to move
2 rooms on a few occasions. Why was that?

3 A. I think that was to help staff manage kind of when there
4 were issues between women, to break people up, and
5 Marion was quite compliant and you could kind of reason
6 with her. She's not going to probably say no. So
7 I think, really, that nature was a bit, you know -- it
8 was unfortunate --

9 Q. Taken advantage of?

10 A. -- that she -- you know, sometimes the rooms were better
11 than the rooms she'd been in and sometimes she didn't
12 like them. But, you know, because she'd said yes and
13 been persuaded to move. But, really, by the end I think
14 it was maybe three or four times that --

15 Q. That she moved rooms?

16 A. Yeah. I think I was a bit -- feeling, you know, that
17 that was a bit much really.

18 **THE CHAIR:** Can I be clear, was this during the Covid period
19 or was this before Covid actually started?

20 A. December 2018. So she was there for about a year
21 before -- a year and a bit before lockdown and then
22 obviously she was there throughout the whole of Covid.

23 **THE CHAIR:** But these changes you noticed in terms of the
24 acuity of people coming into the place.

25 A. Yeah, I think it definitely got worse.

1 **THE CHAIR:** Over Covid?

2 **A.** Yeah, definitely.

3 **MS LLOYD-OWEN:** She doesn't transfer to Aurora Ward, which

4 we're going to come to in a moment, until 16 September

5 2021?

6 **A.** Yeah.

7 **Q.** So she was on Fuji Ward for quite some time?

8 **A.** Yeah, and it was longer because of Covid, really,

9 because everything got delayed. Obviously, people

10 couldn't go and do the leave and things that they -- you

11 know, she would have progressed probably quicker but --

12 Covid. So ...

13 **Q.** So she's on Fuji Ward for approaching three years?

14 **A.** Yeah.

15 **Q.** So quite a long time for staff to get to know her --

16 **A.** Yeah.

17 **Q.** -- and for her to develop relationships.

18 **A.** Mm.

19 **Q.** She's then transferred to Aurora Ward on 16 September

20 2021; is that right?

21 **A.** Yes, that's correct.

22 **Q.** This was a ward, is this right, that was used to prepare

23 patients for discharge?

24 **A.** Yes.

25 **Q.** This transfer was part of Marion's original care plan

1 and had been agreed by the Ministry of Justice and the
2 Jersey authorities?

3 **A.** Yes, that had been agreed at the end of the court case
4 that that was the path. Some women went to another
5 ward, which was a low secure ward, called Causeway, but
6 Marion's -- I think they wanted to check because Aurora,
7 you had more freedom, I think, and you were expected to
8 go out every day, you were expected to, you know, join
9 in community things. Maybe have a voluntary job and
10 things like that. So it was preparation for discharge.

11 **Q.** Before the transfer took place, there were about two
12 weeks of daily visits to Aurora Ward; is that right?

13 **A.** Yeah.

14 **Q.** You say in your statement that this is slightly longer
15 than the usual schedule of visits to the new wards due
16 to Marion's history?

17 **A.** That's what Marion told me: that Dr B, the psychiatrist,
18 had told her that he wanted her to have a longer
19 transition to the new ward, which I kind of, you know,
20 felt reassured by, that they were taking into account
21 what had happened at prison, that transitions for her
22 were -- could be difficult and change in general.

23 So I was quite reassured, hearing her tell me that.
24 And she did do that. It's sort of you go for a few
25 hours and then you have a meal, then, you know, it sort

1 of builds up gradually.

2 **Q.** How did you become aware that Marion was being
3 transferred to Aurora Ward?

4 **A.** I think it had been talked about at the -- there were
5 Section 117 meetings, that that was her plan, but
6 I don't think anyone specifically contacted me to say.
7 It was all through Marion and most of what I know is
8 through what Marion told me, not a professional.

9 **Q.** The Section 117 meetings, they were the six-monthly
10 meetings, were they?

11 **A.** Six-monthly Care Programme Approach meetings.

12 **Q.** You've said that most of what you learnt was through
13 Marion. As far as you are aware, was there anything to
14 suggest that Marion didn't consent for information to be
15 shared with you by staff?

16 **A.** No, not that I'm aware of.

17 **Q.** You were in those six-monthly meetings --

18 **A.** Yeah.

19 **Q.** -- and contributing and hearing information through
20 those; is that right?

21 **A.** Yeah, and sort of -- I did attend in person pre-Covid
22 but, after Covid, they just kept them virtual. So it
23 was always a virtual meeting. Obviously, the people
24 that worked at Brockfield House and Marion would be in
25 one room but I would be joining them virtually.

1 Q. I want to ask now just about the physical environment of
2 Aurora Ward, where Marion was detained for almost six
3 months, so from the 16 September 2021 until her death on
4 4 March 2022. Can you tell us a little bit about
5 Marion's living arrangements on this ward in particular?

6 A. Yeah, I never visited the ward and I was never asked to
7 go there and, obviously, by that time, Marion -- I was
8 able to go and pick Marion up and we were going out. So
9 I never visited her on the ward. The only time I went
10 was to collect her possessions after she died. So that
11 was the first time I saw her room, which was a lovely
12 room with a view of the sort of fields and things.

13 So within the ward, as I understand it, was a series
14 of flats. So one-bedroom, two-bedroom and three-bedroom
15 flats.

16 Q. Yes.

17 A. There was also a communal area, kind of a bit similar to
18 Fuji Ward with a lounge area. So within the flats
19 people would have their own bedroom, lounge, kitchen and
20 bathroom, as well, and they'd have the key to that flat.
21 And she -- she was really looking forward to going to
22 Aurora Ward because she saw it as sort of moving towards
23 discharge but, also, two friends that she'd made, they
24 were all sort of vying to get on to Aurora Ward at the
25 same time so they could share one of these flats, so it

1 did work out in the end and the three of them did share
2 a flat and they did sort of cooking together and stuff.

3 And then one of them unfortunately relapsed, so she
4 moved wards and the two of them then were together, so
5 they moved to a two-bedroom flat. But it is sort of --
6 they've got their own flat but Marion's flat, the door
7 sort of came out onto the staff office. So it's a bit
8 weird to explain and they also had like outside areas
9 but they weren't ones that you could -- they were sort
10 of enclosed outside areas, sort of designed so that no
11 one could hurt themselves but they could have some fresh
12 air.

13 **Q.** So with safety in mind --

14 **A.** Yeah.

15 **Q.** -- it was approaching what it might be like to live in
16 a flat outside?

17 **A.** Yeah, and it was towards the front of the building, sort
18 of above the reception area, so yeah.

19 **Q.** I think it's originally the patients -- that we'll be
20 referring to as Patient T and Patient C --

21 **A.** Yeah.

22 **Q.** -- that Marion is in a three-bedroom flat with --

23 **A.** Yeah.

24 **Q.** -- and then a two-bedroom flat with Patient C
25 thereafter. What did you understand from Marion or from

1 what you've learned since, as to Marion's routine,
2 whilst she was on Aurora Ward?

3 **A.** I think she'd get up in the morning -- they were
4 expected to clean the flat, I think, like a bleach
5 tablet and they had to wash the floors and things. And
6 then they'd have the morning meeting, I think probably
7 about 9.00 or 9.30, which the staff would relay to them
8 any information they needed, sort of housekeeping
9 issues, and of relevance to Marion was like the Covid
10 lockdowns when they might end, if they were happening.

11 **Q.** Yes.

12 **A.** And then that people could go out, according to if they
13 had a section. They all had like signed sections,
14 paperwork. So I think Marion was allowed to go to
15 Wickford two or three times a week, which is the nearest
16 sort of town, to go shopping and she used to go
17 swimming, go to the local gym and, you know, things like
18 that. And they were looking at voluntary work for her,
19 as well. Some people did voluntary work. So everyone
20 kind of more or less went out most days.

21 **Q.** Yes.

22 **A.** So ...

23 **Q.** Then in terms of engagement with Marion, is it your
24 understanding that she was involved in her care plans
25 and planning for her care?

1 **A.** Yes, I think she was, through the fortnightly ward
2 rounds. I think the idea is the key worker has
3 a meeting with the patient, they discuss what she wants
4 to bring up at ward round every fortnight, which was
5 normally things like, "I need a section signed because
6 I'm going to see my sister", or, "I want to do this".

7 **Q.** Yes.

8 **A.** And anything else: any health issues or referrals that
9 she wanted. So she was used to that process, and it
10 seemed to work quite well.

11 **Q.** Then, in terms of the -- you've explained that the more
12 formal Care Programme Approach meetings, the Section 117
13 meetings, took place every six months --

14 **A.** Yeah.

15 **Q.** -- and you were engaged in those meetings. How
16 informative and constructive did you find these
17 meetings?

18 **A.** Yeah, they were fine. Everyone just gave a report like
19 the OT, the key worker and it was kind of what I would
20 expect it to be, really.

21 **Q.** Then outside of those meetings what contact did you have
22 with ward staff?

23 **A.** I didn't have any contact with ward staff or the key
24 worker. The only person that contacted me was the
25 social worker. Marion had a social worker --

1 Q. Yes.

2 A. -- and the original one used to contact me quite a lot.

3 And then he went on secondment, I think, and she got

4 another social worker, who was a very experienced

5 forensic social worker, but she didn't really contact me

6 very much at all. Only when absolutely sort of

7 necessary, whereas I think the other one used to just

8 sort of check in from time to time.

9 Q. Yes.

10 A. Nobody ever asked like, "How did your visit go?" There

11 was no -- there didn't seem to be any feedback loop.

12 Q. So the social worker, is that right, would have been

13 attending the multidisciplinary --

14 A. Yeah.

15 Q. -- team meetings?

16 A. Yeah.

17 Q. So when there was that social worker who reached out and

18 had regular contact, you were given a lot of

19 information, would that be fair?

20 A. I think he'd -- he used to just generally check in.

21 Whether it was because it was at different stage of the

22 process and she was on Fuji Ward, I don't know, or

23 whether it was just different styles.

24 Q. Yes.

25 A. For example, I've read, since Marion died, that, you

1 know, the social worker had thought in January 2022 that
2 Marion was completely clueless about what living in
3 a supported housing environment was going to be --

4 **Q.** Yes.

5 **A.** -- and she was just focused on the fact that it was
6 where I live and the place it was going to be. But that
7 was complete news to me when I read it because this was
8 never mentioned to me, and nothing -- I haven't read
9 anything in the notes -- and I've had all the notes for
10 the last six months Marion was alive -- that suggested
11 anyone discussed that with her, even though they'd
12 written it down and they'd discussed it at MDT. I think
13 it was in the January, when -- or the end of December,
14 possibly, 29th, or something. There was no -- that
15 wasn't fed back to me, you know. And when I suggested
16 Marion should come and live near me rather than return
17 to Jersey, again, you know, no one sort of discussed
18 with me what that would be like, or -- despite Marion
19 giving permission to the social worker on the
20 11 February, she hadn't phoned me.

21 **Q.** So is this right --

22 **A.** -- about the accommodation. She never got in contact.
23 In fact, when she phoned to say Marion had hurt herself,
24 I said, "Oh, great". You know, I said, "Oh, great,
25 thanks for phoning, I was just going to ask you about

1 the accommodation".

2 Q. We will come to what was communicated to you after
3 Marion's death but is it right that, in terms of the
4 discharge plan for Marion, that there had been
5 discussion between you and Marion of whether or not she
6 might want to live near where you lived --

7 A. Yeah.

8 Q. -- rather than going back to Jersey?

9 A. Yeah. I felt she'd be isolated in Jersey because my
10 parents are elderly and she lived to an annex of their
11 house, and they'd got their own (... redacted ...) So
12 it's kind of -- it felt to me that it would be better
13 for her to sort of start anew, and she didn't really
14 have any friends in Jersey. So it wasn't like this
15 existing community she was returning to.

16 Q. In terms of the discussion that you had, you say in your
17 statement that you've raised this and then you
18 understood from Marion that that was the new plan for
19 discharge?

20 A. Yeah.

21 Q. We've touched on this but to what extent was there any
22 contact from those who were considering her discharge
23 with you from the ward staff?

24 A. There just wasn't, really. That just became the plan
25 and one of the other issues, which you'll probably --

1 you know, there wasn't any relapse prevention planning
2 done, and the -- you know, in a timely way, in my, you
3 know, view.

4 **Q.** Yes.

5 **A.** Because discharge was being discussed, she was meant to
6 be meeting with this supported housing, which was, you
7 know, going to be a stressful event for Marion but
8 there'd been no, you know, discussion with her or myself
9 about it.

10 **Q.** I want to come to that in a moment. What I just want to
11 touch on first of all is the therapeutic care that she
12 received --

13 **A.** Yeah.

14 **Q.** -- and the medication that she was receiving. I think
15 you explain that, in relation to Marion's paranoid
16 schizophrenia, medication was the main treatment; is
17 that right?

18 **A.** Yeah, and she'd been on the same medication for many
19 years.

20 **Q.** Yes, and the responsible clinician for Marion at EPUT's
21 Brockfield House was Dr B. You say in your statement
22 your impression was that he had a very good
23 understanding of Marion's mental health history, risk
24 factors and the plan for how she could be treated at
25 Brockfield House; is that right?

1 **A.** Yes, he seemed to have.

2 **Q.** The main treatment for her emotionally unstable
3 personality disorder traits, was DBT, so dialectical
4 behaviour therapy?

5 **A.** Yes.

6 **Q.** What was your understanding of what that treatment
7 consisted of?

8 **A.** It was a series of, I think, four -- I don't know what
9 they -- distress tolerance, mindfulness -- I can't
10 remember the other two. But it was like a form of CBT
11 but for people -- it's a known way of working with
12 therapeutic approach for people with personality
13 disorders. It was very well established there. They
14 had a very good programme. But alongside people
15 attending groups and completing these four sections --
16 and there was probably a week or two break in between --
17 they also had a one-to-one with a psychologist, the ward
18 psychologist. So Marion did have that up until when the
19 first psychologist left and then she didn't have it
20 again after that. Even when the new psychologist came,
21 she didn't kind of get that level of involvement.

22 **Q.** So those were regular sessions, one to one?

23 **A.** Yeah, I think it was weekly.

24 **Q.** Weekly sessions?

25 **A.** Yeah.

1 Q. Then there's a period, is this right, of about eight
2 months, where there is nobody in post --

3 A. Yeah.

4 Q. -- as a psychologist on the ward?

5 A. Mm.

6 Q. Then a locum, Mr D --

7 A. Yeah.

8 Q. -- becomes the psychologist?

9 A. Yes.

10 Q. Is it right that, effectively, there wasn't then
11 consistent weekly sessions of one to one thereafter?

12 A. No, I think he was supposed to be picking up the sort of
13 gaps that were still there but in -- in the event,
14 Marion suggested something to him and they did that
15 instead.

16 Q. Is this the workaround --

17 A. The self-forgiveness --

18 Q. The self-directed work in relation to self-forgiveness?

19 A. Yeah.

20 Q. That was in relation to the attack --

21 A. The assault.

22 Q. The assault?

23 A. Yeah, on her ex-partner, yeah.

24 Q. I think you mentioned later on in your statement that
25 Marion was going to meet up with the ex-partner towards

1 the end of 2021?

2 **A.** Yeah.

3 **Q.** Do you know whether that work had been planned in
4 preparation for that meeting?

5 **A.** No, I think he just randomly phoned and said he was in
6 the UK and --

7 **Q.** I see.

8 **A.** -- and it sort of then --

9 **Q.** Yes, so it was coincidence of timing --

10 **A.** Yeah.

11 **Q.** -- rather than being built up to. One --

12 **A.** Unfortunately, that seemed to take the place of
13 discharge planning. It was kind of just that, then, and
14 although they kept saying it's -- you know, it'll be
15 done by February, it'll be done by February, it never
16 happened and no one seemed to pick that up.

17 **Q.** So this is the relapse prevention plan; is that right?

18 **A.** Yeah.

19 **Q.** So that had originally been due to be completed by
20 February 2021?

21 **A.** No, 2022.

22 **Q.** 2022, thank you.

23 **A.** Yeah.

24 **Q.** So that didn't, in fact, get completed?

25 **A.** No, I think the idea was they would then just do that

1 afterwards, after she'd finished this self-forgiveness.
2 But, to me, it was quite pressing because she was quite
3 deep into looking at places to live, having meetings and
4 discussions and, because of what happened when she was
5 in prison, you know, it felt -- actually she did, you
6 know -- looking back anyway, obviously, it feels like
7 that should have happened.

8 **Q.** So you think more time and earlier --

9 **A.** Yeah.

10 **Q.** -- that the relapse prevention --

11 **A.** Well, especially that it seemed to be recorded that she
12 didn't have a clue.

13 **Q.** Yes.

14 **A.** She didn't have any concept of what it was going to be
15 like. This was the first time she'd lived
16 independently, you know, for many years because she'd
17 had a partner for over 20 years. You know, this was
18 quite a big deal for her. But, you know, that didn't
19 seem to be taken into account.

20 **Q.** Then another element of treatment was the occupational
21 therapy services-led activities for which, is this
22 right, there was a therapeutic timetable on the ward?
23 What was your overall view of the occupational therapy
24 programme?

25 **A.** Yeah, that seemed very good and again the staff, two of

1 the staff in particular, the senior OT -- and then, you
2 know, they were consistent throughout the whole time
3 Marion was there. They knew Marion very well.

4 **Q.** Yes.

5 **A.** Her -- you know, her likes and dislikes. So yeah, I was
6 positive about the OT.

7 **Q.** Then you outline in your statement that Marion had
8 a number of physical health needs. What was your
9 impression of the approach taken to her physical health
10 while she was there?

11 **A.** Yeah, that was very positive. You know, they had
12 a doctor and, if she reported any health needs, that
13 did -- you know, she could see the doctor and they made
14 referrals on, if they couldn't deal with it themselves.
15 So it was -- it was very positive.

16 **Q.** And that was a doctor, a physical health doctor, that
17 was based at Brockfield House?

18 **A.** I think so or there was a duty doctor sort of system.

19 **Q.** Yes. I want to ask you now specifically about your
20 experience regarding Marion's key worker which you
21 describe in your statement as mixed.

22 **A.** Yeah.

23 **Q.** What was your impression of Marion's key worker while
24 she was at Fuji Ward?

25 **A.** Well, as I say, I only met her in passing on the -- when

1 I was having a picnic with Marion in the grounds on
2 a visit. But Marion spoke very highly of her and
3 I think I read in the -- Marion was having a wobble
4 once, something to do with her ex-partner, and she'd
5 actually confided in her, which I thought, you know,
6 that is quite a big deal for Marion. So she must have
7 felt confident in her. And I remember Marion laughing
8 because, with the new psychologist, Marion was getting
9 fed up that he was sort of going over her background and
10 things like that, and she just wanted to get on with,
11 you know, heading towards discharge, sort of thing.

12 And the key worker sort of encouraged -- brought
13 that up at the ward round, you know, which not everyone
14 would, would they, necessarily, given he was sitting
15 there as well? So I felt that she was a good advocate
16 for Marion. But on Aurora Ward, I felt the key worker
17 hardly knew her and gave evidence that, you know, she
18 didn't even think that Patient C was Marion's friend.
19 She'd been --

20 **Q.** That was the patient that was living in the flat?

21 **A.** Yeah, they'd been friends for years. So I just felt
22 like she didn't have the same quality about her as
23 a mental health nurse. But, also, I suppose then you
24 have to query that this is a more risky environment and,
25 actually, you haven't got anyone that's got that

1 solid -- you know, when you move wards you go from
2 someone that knows you very well to someone that doesn't
3 know you, but you are going out into the community. But
4 then, on the other hand, obviously patients aren't on
5 the ward as much, on that ward. So there could be less
6 time to get to know them.

7 **THE CHAIR:** Do you think there might have been some element
8 of wanting to give people more independence?

9 **A.** There could have been, yeah, and maybe it wasn't such
10 a big deal for Marion at that time, I don't know. But
11 I know that she did say to me, you know, that she didn't
12 really click with her.

13 **MS LLOYD-OWEN:** I think you say in your statement that this
14 was a key worker who worked mainly nights; is that your
15 understanding?

16 **A.** Yeah, although I think when I did check that, I don't
17 think she did always work nights. But maybe that was
18 the time that she had, you know, half an hour to go
19 through things with Marion. I don't know. But I don't
20 think they really had any rapport. So, you know, that
21 wasn't so positive.

22 **Q.** In terms of the contact that you had, beyond that one
23 meeting in passing with the original key worker, did you
24 have any direct contact with the key worker --

25 **A.** No.

1 Q. -- or the subsequent psychologist, Mr D?

2 A. No, I didn't.

3 Q. I just want to turn now to just ask what your
4 understanding was. I think you say in your statement
5 you didn't make any complaints at the time?

6 A. No.

7 Q. But what was your understanding as to whether, if there
8 was a concern you had, as a family member, how you could
9 raise that? Were you given information about that?

10 A. I think it would be probably through the social worker.
11 I think I was sent some information at the start but it
12 was directed at patients --

13 Q. Yes.

14 A. -- how patients could make complaints.

15 Q. I see.

16 A. So it wasn't really about how you could make
17 a complaint.

18 Q. I want to turn now to ask about your concerns regarding
19 the assessment of risk on both Fuji and Aurora wards.
20 What did you understand to be the general approach to
21 determining whether Marion could have items like shoe
22 laces or razors at Brockfield House?

23 A. I think that was determined at a ward round.

24 Q. Yes.

25 A. And obviously I didn't know all the ins and outs.

1 I knew that Marion was, like, couldn't have shoelaces
2 for quite a long time and I'd see her, like, wearing
3 converse but without laces. She was getting fed up of
4 that. But she could ask and it would be granted but it
5 was really only at the inquest that I found out that
6 originally they said that she shouldn't have quite a few
7 items until after the court case was over.

8 **Q.** Yes.

9 **A.** But then she seemed to have been given those items with
10 Dr B's knowledge and it had obviously been agreed
11 somewhere. But there was no record found -- the counsel
12 for EPUT looked through the records one evening of the
13 inquest, and couldn't find any record of why that
14 decision changed for her to be given those items sooner.
15 So there didn't seem to be any sort of record of, like,
16 "Well, we were saying that but we now thought this, and
17 the reasons for it are this, that and the other", that
18 you would expect. They just didn't exist.

19 **Q.** So there were items that were considered of potential
20 risk to Marion, and you have concerns now that either
21 there wasn't recordkeeping of those decisions being
22 made --

23 **A.** Yeah.

24 **Q.** -- or they were being given to her before decisions had
25 been made; is that right?

1 **A.** No, I think decisions were made but they just weren't
2 recorded.

3 **Q.** They hadn't been recorded?

4 **A.** Yeah.

5 **Q.** I want to turn now to your concerns regarding the
6 adequacy of risk assessments in relation to sharps,
7 specifically. Marion underwent a sharps assessment on
8 7 June 2019, whilst she was on Fuji Ward; is that right?

9 **A.** Yeah, that's correct.

10 **Q.** That was before she started doing any self-catering?

11 **A.** That was so she could start doing -- I think, about once
12 a week the OT would buy ingredients, she'd decide what
13 she wanted, like spaghetti bolognese, and then they'd go
14 and buy the ingredients, and then they'd be with her in
15 the kitchen, so she had to do this knife -- it was
16 literally cutting a butternut squash, that's what she
17 had to do, and that's what the assessment was. It was
18 a functional assessment: could she use a knife.
19 Obviously, I didn't know this but I've subsequently read
20 that that was the only assessment Marion had about
21 having access to knives.

22 **Q.** So as against an assessment whether Marion was safe
23 unsupervised having knives, this was about functionally
24 was she safe to cook in the kitchen?

25 **A.** Yeah, and also it came up at the inquest that the OT

1 that was cooking with her was locked in the kitchen with
2 her, with a knife, and there was no assessment of
3 whether that was safe for the staff member, either.

4 **Q.** I see.

5 **A.** Because it was all about: could she cook? Could she use
6 a knife to cut things with?

7 **Q.** So this was a generic risk assessment --

8 **A.** For the whole of Brockfield House.

9 **Q.** Was that a risk assessment that you understand was
10 conducted by the OT, the occupational therapist?

11 **A.** Yes.

12 **Q.** You identified in your statement that a major change for
13 Marion after she transferred to Aurora Ward was that she
14 would have unsupervised access to knives; is that right?

15 **A.** Yeah, which I didn't know until after her death.

16 **Q.** At or before the point of transferring to Aurora Ward,
17 did an assessment of the risk of Marion having
18 unsupervised access to knives or sharps take place?

19 **A.** No, they just relied on this functional assessment that
20 the OTs had done and I believe I remember reading
21 somewhere that it was on a different system, so the
22 staff couldn't even really access it. They just knew it
23 had happened and that was good enough for them on Aurora
24 Ward.

25 So, in a way, you kind of think: were they safe?

1 Was the person Marion was sharing a flat with safe?

2 Because no one had assessed any of these risks. It was
3 just literally, "Can you cut a vegetable?"

4 **Q.** So the fact of there having been a risk management is
5 shared?

6 **A.** Yes.

7 **Q.** But the detail of that and the nature of that --

8 **A.** Yeah, and there was the HCR-20, I think it's called,
9 which was a forensic risk assessment, which was updated
10 every six months.

11 **Q.** Yes.

12 **A.** But that, I never saw that. That's never been provided
13 to me. But that -- I don't think that went into detail
14 about, you know, access to knives and things like that
15 in, like, where are we at now? It was just this had
16 been custom and practice at Brockfield House, obviously
17 probably since it opened, and nobody had sought to think
18 that this was a little bit odd.

19 **THE CHAIR:** So can just understand this: you're concerned
20 about what was actually done at some stage on the ward
21 to try to identify whether or not Marion was safe to use
22 a knife.

23 **A.** Yeah.

24 **THE CHAIR:** You say that that was based solely on whether
25 she could actually, as you say, functionally use

1 a knife.

2 **A.** Yeah.

3 **THE CHAIR:** But you did refer earlier to there being risk
4 assessment about her access to knives, which had not
5 been --

6 **A.** Well, risk assessment to sharps, I would say, things
7 like to have -- you know, a razor, shave her legs, and
8 things, and other sharp items --

9 **THE CHAIR:** And that --

10 **A.** -- or glass items, like face creams in glass things.
11 You know, it was things like that.

12 **THE CHAIR:** And that had concluded she was safe to, but --

13 **A.** Well, it hadn't been --

14 **THE CHAIR:** But it hadn't been recorded, you say?

15 **A.** It hadn't been recorded. She was given access to those
16 things but there was no record of why she was given
17 access to those things at the time she was given access
18 to them.

19 **THE CHAIR:** So you don't know whether there was any risk
20 assessment about those either?

21 **A.** No.

22 **THE CHAIR:** Thank you.

23 **A.** That was just the process that -- you know, that there
24 was, that gradually you, you know, could have more
25 access to things but in her case ...

1 **MS LLOYD-OWEN:** I think you refer in your statement as well
2 to a risk profile completed by the key worker. As far
3 as you're aware, did that document or any other risk
4 assessment look at the risk arising from Marion's
5 history of using sharps against herself and others?

6 **A.** No, and I don't think staff were that aware, on the day
7 that she died, that that was an issue for Marion.

8 **Q.** So as you understand it, in terms of the extent to which
9 there have been an assessment of Marion's individual
10 risk in relation to knives and sharps, because of her
11 history, what was -- what's your current impression from
12 the evidence you heard at the inquest and before?

13 **A.** Well, it was completely inadequate. You know, the fact
14 that anyone could move to a different ward and just
15 overnight go from not having -- only having supervised
16 access to knives to having unsupervised, they could just
17 ask for a knife and be given it, and there was no -- it
18 was the fact they changed wards that -- it wasn't to do
19 with any risk assessment of the individual. It was just
20 a *carte blanche* for everyone.

21 **Q.** At Marion's inquest, the jury concluded that, in the
22 context of her history of self-harm and violence
23 directed at others, including the use of knives, that
24 there was an absence of focused risk assessment with
25 respect to her having unsupervised access to knives --

1 **A.** Yes.

2 **Q.** -- both prior to her transfer --

3 **A.** Mm.

4 **Q.** -- and following her transfer to Aurora Ward; is that

5 right?

6 **A.** Yes, that's right.

7 **Q.** And that both of those omissions possibly contributed

8 significantly to her death?

9 **A.** Yes.

10 **Q.** I just want to ask a few questions -- and then it may be

11 a good moment to take a break, about --

12 **THE CHAIR:** Can I be clear --

13 **MS LLOYD-OWEN:** Yes, of course.

14 **THE CHAIR:** Those observations, as I understand it, from the

15 statement, it says that the matters in question

16 "possibly" made a significant --

17 **MS LLOYD-OWEN:** Sorry, yes, that's exactly right.

18 **THE CHAIR:** Thank you.

19 **MS LLOYD-OWEN:** In relation to the HCR-20 risk assessment

20 you mentioned, is it also right that EPUT's safety

21 incident investigation report found that that was last

22 updated in August 2021, when it should have been updated

23 again in February 2022.

24 **A.** February yes, that's correct.

25 **Q.** And, again, noted as an area of concern the lack of

1 a sharps assessment. I want to just understand the
2 process of, beyond the risk assessment, when Marion
3 would be issued with sharps, including knives on Aurora
4 Ward, and what you would understand to have been the
5 monitoring system or the process that took place when
6 she attended to the office, say, and asked for a knife?
7 What would happen?

8 **A.** Well, there was -- produced a few days or a week before
9 the inquest was a signing-out sheet, which showed
10 a handful of entries of everyone that had had a sharp
11 issued, it could be a razor or whatever, on that ward.
12 And going back some months, there was only about ten
13 entries for a ward of 12 people, who were all
14 self-catering. And it -- and the police had mentioned
15 that in their report for the inquest, as well, that, you
16 know, very few signed out -- very few sharp items had
17 been signed out in a number of months, and then staff
18 said, "Well, we didn't always record it".

19 So, again, it was custom and practice to issue
20 knives and people could say which -- there was three
21 different sizes: they could say whatever size they
22 wanted. Staff said they relied on this 2019 assessment
23 that had been done and, obviously, if someone was
24 behaving aggressively they would have said something,
25 but if, you know, all things being equal, they would

1 just issue them and they wouldn't always record it.

2 But I feel that that -- again, completely unsafe.
3 Where was the auditing of this? You know, and they
4 didn't seem to have a process for it. But this must
5 have been going on a long time. But also, it was
6 a missed opportunity because it showed that, on the
7 three occasions Marion was issued with a knife,
8 apparently, that they actually did write down, she
9 always returned it within, like, 15 to 30 minutes of
10 cooking something.

11 **Q.** So there was a clear pattern --

12 **A.** There was a clear pattern but, again, they had a policy
13 of, you know, they didn't come to collect the knife: the
14 person brought it back to them. But this was all in the
15 contact -- context where there was no risk assessment
16 based on people's background and their crimes, I guess
17 you could say, of knife use.

18 So I feel -- you know, when I saw that, I thought,
19 "Well, the staff have been at risk here". You know,
20 potentially there's a lot of unknown risk on Aurora Ward
21 that no one seems to have worried about.

22 **Q.** Then is it right that, at that time, EPUT had a daily
23 security nurse system in place?

24 **A.** Yes. So the person that issued the knife wasn't the one
25 that necessarily signed it out. That was whoever was

1 nominated to be the daily security nurse, and I guess
2 that's maybe where this system fell down. And, I mean,
3 I've never -- I never formally asked the question in the
4 inquest but I kind of asked: why on the day she died was
5 it recorded or was it recorded afterwards? I don't
6 know.

7 **Q.** Yes, and was it the practice, as you understand it, to
8 ask any questions about why the patient wanted to take
9 out a knife?

10 **A.** I think they -- I think they did sort of, you know --
11 "I'm cooking lunch", or something like that but, on the
12 day Marion died, you know, she hadn't been to the shop
13 since 8 February. This was 16 days into a lockdown and
14 the staff were cooking the meals. And she asked for
15 a large knife. And, you know, what did she have that
16 was fresh to actually cook?

17 It felt like autopilot, really, that people were so
18 busy, the staff were so busy, all the patients were on
19 the ward instead of being off the ward. There was only
20 two of them, that actually they were just on autopilot.
21 They weren't, you know -- and when the person who found
22 Marion came into the flat and called her name, she was
23 coming to ask if she wanted to have an omelette, which
24 was providing lunch, even though Marion was saying she
25 was cooking her own lunch. So there was a lot of

1 obviously, Killing Eve is about someone that uses knives
2 to hurt people and kill people. So he said, "I wouldn't
3 allow" -- Marion said to me, "I wouldn't allow some
4 people to have this but you're okay". And I felt that
5 was a very strange decision.

6 I didn't do anything about it but I just felt --
7 that just seemed odd to me and, also, going back to when
8 she hurt her partner in 1999, that was after -- part of
9 the run-up to the incident was that they'd watched
10 a violent -- I think it was Angel Heart or something --
11 a violent DVD. So, yeah. I mean, I didn't know that at
12 the time. She told me. But when I read about it since
13 she's died, it sort of increased my concern that it
14 seemed to be very odd decisions were being made,
15 potentially, or what was the reason?

16 **Q.** Yes.

17 **A.** And I don't think that was probably ever recorded, but
18 I don't know.

19 **Q.** Turning now to what you talk about happening in the
20 weeks leading up to Marion's death on 4 March, you
21 outline in your statement that Marion was impacted by
22 a number of changes which had a cumulative effect,
23 raising her stress levels to such an extent that she
24 fatally self-harmed on 4 March. So I want to just talk
25 if we can in turn about those changes.

1 In terms of your understanding now, how she coped
2 with changes to her routine, what's your view on that
3 and how she managed?

4 **A.** I think that was one of the things: changes or stressful
5 events. I didn't know to the extent I know now, having
6 read all the reports, the expert reports, and having had
7 access to them I know a lot more, but yeah, change and
8 things like that was difficult for her. I mean, if
9 I had to change the day of my visit, we'd discuss that
10 there'd be a reason and she'd accept it. But changes in
11 her life, in her relationship and in her routine had
12 often, I think, been seen as the precursor to incidents.

13 **Q.** You record in your statement examples of Dr B and Ms C
14 describing the difficulties she had?

15 **A.** Mm.

16 **Q.** You say that:

17 "Ms Michel has also identified that she's quick to
18 relapse when she's stressed, in addition to change in
19 her sleep and routine, resulting in her relapse and her
20 being very regimented in her routine."

21 **A.** Yeah.

22 **Q.** So in terms of the changes that were happening in the
23 weeks leading up to 4 March, I want to ask firstly about
24 the effect of the lockdown on Aurora Ward. At the start
25 of 2022, you explain that Marion had told you that there

1 were -- there was an increase in Covid-19 infections; is
2 that right?

3 **A.** Mm, I think she'd obviously been at Brockfield House for
4 the whole of the pandemic, so, obviously on Fuji Ward
5 there were activities in the ward, she didn't always
6 have leave at that time. So life just kind of went on
7 as normal.

8 **Q.** Yes.

9 **A.** Nothing substantially changed. It was the same food,
10 the same routine, more or less. They couldn't go to the
11 gym and places like that but, in Aurora Ward, they did
12 have a lockdown, just after Christmas. Again, EPUT's
13 dates are all over the place. They didn't record the
14 dates of Covid lockdowns, clearly.

15 **Q.** I think you say in your statement that there's some
16 confusion as to when it ended but that the start date
17 was 14 February.

18 **A.** Including the one -- yeah. But there was also the one
19 prior to that where they said it lasted, I think, until
20 26 January but I actually went out with Marion on
21 23 January. That was the last time I saw her. So they
22 didn't record the dates of these lockdowns. So the
23 difference between that lockdown and the one that, you
24 know, she died after -- during -- was that they'd kind
25 of -- I think they'd known there was going to be one --

1 maybe someone had got ill and there was a general sense.
2 So her and her friend had been into Wickford, done
3 a massive shop and got a taxi back. So they were sort
4 of -- life carried on as normal.

5 **Q.** Was this 8 February?
6 **A.** They were self-catering.

7 **Q.** Is that 8 February? Is that right?
8 **A.** No, this was in -- there was one just after Christmas,
9 December 2021 until January 2022. So this was another
10 lockdown she'd experienced on Aurora Ward, and the point
11 I'm making is not much changed during that for her
12 because she'd been able to get a lot of shopping in.

13 **Q.** I see.
14 **A.** They'd anticipated a lockdown. So life just kind of
15 carried on, and then it finished.

16 **Q.** Can I just ask you to turn up page 34, paragraph 166.
17 It talks there about lockdowns between 24 December 2020
18 and 25 January 2021.
19 **A.** Yeah, the date is wrong because I went out.

20 **Q.** Yes, I wondered. So that should in fact be 2021 to
21 25 January 2022?
22 **A.** Yeah, sorry, yeah.

23 **Q.** So there's a period of lockdown --
24 **A.** Which she wasn't on Aurora Ward on that date. I'm
25 sorry.

1 Q. No, indeed. No, that's no problem at all, it's helpful
2 to clarify. So there's a period when she has
3 anticipated the lockdown, so got in food with her
4 flatmate, Patient C?

5 A. Yeah.

6 Q. Therefore their meals continue as property?

7 A. Yeah.

8 Q. Their routine of food preparation --

9 A. Yeah, everything continues, yeah.

10 Q. But in relation to the lockdown --

11 A. I don't think it was as long. Although it looks like
12 it's very long, I don't think it -- I actually think it
13 didn't start until after Christmas. But that's just my
14 recollection.

15 Q. I see. So there may be an issue with those dates but
16 certainly there was one around the start of the year --

17 A. Yeah.

18 Q. -- and then the second one, which is the one we are in
19 at 4 March --

20 A. Yeah.

21 Q. -- maybe started around 14 February, there wasn't an
22 ability to prepare in advance; is that right?

23 A. No. So she had last gone shopping on 8 February and she
24 hadn't been -- because she didn't have a spleen, she was
25 more at risk of infections. So I think that was

1 a particularly bad time for Covid infections so I think
2 she'd been quite careful and she wasn't going out as
3 much. And so she'd been out to do some shopping on the
4 8th, and then obviously hadn't been again, and it
5 started on the 14th. And, obviously, she wasn't aware
6 it was going to start this time.

7 **Q.** So, just in terms of our understanding of how much this
8 would have affected Marion's routine, how much of her
9 day was based on food preparation, what she ate, that
10 sort of thing?

11 **A.** Well, I think it was quite important to her, food. She
12 was a comfort eater.

13 **Q.** Yes.

14 **A.** She liked to have, you know, a chocolate bar every day,
15 normally. She could -- there's a shop there she could
16 have gone to but, obviously, they couldn't go during
17 Covid. She liked to make home-cooked meals, not all the
18 time, but she did like cooking. And she didn't like
19 what she called the trolley food, which was the food
20 they had on Fuji Ward for patients, you know, the food
21 provided by Brockfield House. So yeah.

22 **Q.** And so, by this point, she's, on Aurora Ward. She can't
23 make the food for herself. She's reliant presumably on
24 ward staff. What was the arrangement during the
25 lockdown as to how meals would be prepared? What would

1 happen?

2 **A.** Well, what she said to me was initially the staff did
3 like a small shop, maybe like 10 to 15 items for
4 everyone, after the lockdown started and people were
5 running out of food. But, obviously, that didn't last
6 very long. So then they were going to get, like,
7 a supermarket online order. That was suggested, but
8 that then didn't happen. Then they were going to have
9 the trolley food, the food provided by Brockfield House,
10 which nobody wanted. So in the end they decided that
11 the staff would cook the meals. So that was a change
12 for Marion because she said she went down to having two
13 meals a day because the staff were cooking meals around
14 their breaks. Sometimes they'd be having their evening
15 meal at 4.00.

16 **Q.** Yes.

17 **A.** So she then didn't want to have sort of breakfast and
18 lunch, so she just had like brunch at 11.00 and then --
19 or sort of breakfast-y food at 11.00, and then at 4.00
20 she would eat her main meal. So that was a change for
21 her and it wasn't, you know -- obviously, she could have
22 been in prison eating prison food, but it wasn't the
23 kind of food that she would have cooked for herself, and
24 would have enjoyed, that was being cooked. So ...

25 **Q.** So for a patient with particularly fixed needs in terms

1 of routine --

2 **A.** Yeah.

3 **Q.** -- the meals that she's eating are changing, the timings

4 of the meals are changing --

5 **A.** Mm.

6 **Q.** -- and she's unable to go out as she normally would?

7 **A.** Yeah.

8 **Q.** You point in your statement to the Patient Safety

9 Incident Investigation report, noting that there was no

10 evidence that recognition of the challenge to those who

11 use food as an element of self-soothing during this time

12 was taken into account.

13 **A.** Yeah.

14 **Q.** And you would agree with that?

15 **A.** Yeah, I mean, I think staff did go to the shop, but I'd

16 got the impression that was more for people that

17 vaped --

18 **Q.** Yes.

19 **A.** -- to get vapes. I'm not sure that Marion was ever able

20 to get a chocolate bar or anything else she wanted.

21 **Q.** Turning to another aspect of change at this time, I want

22 to ask you about the timing and impact of Patient C

23 moving out of the shared flat. What was your impression

24 of the value of and the closeness of that relationship

25 that Patient C and Marion had.

1 **A.** Yeah, it was very important to Marion because Marion
2 hadn't really had friends throughout her life and one of
3 the things that you read in the psychological report was
4 that, you know, loneliness had been an issue for her.
5 So she was suddenly in the company of all these women
6 who had a mental health diagnosis, some of which was the
7 same of hers.

8 **Q.** Yes.

9 **A.** So they had -- some of them had a lot of common. They
10 didn't all get on but she did get on with several
11 patients, two of whom had been discharged and she kept
12 in contact with, and Patient C, as I say, she probably
13 knew for probably two years, through another ward and
14 through going to groups, and then they ended up on
15 Aurora Ward at the same time sharing a flat. So they
16 were close, they cooked together, they went swimming in
17 Wickford together, went to the gym together. So they
18 did quite a lot together and they knew quite a lot about
19 each other's families and they would talk to each other,
20 is my understanding.

21 **Q.** So at this point she's been living with Patient C for
22 more than five months?

23 **A.** Yeah.

24 **Q.** What's your impression now of whether the significance
25 of this relationship was appreciated by staff?

1 **A.** Well, I don't think it was. Her key worker said in
2 evidence at the inquest that she didn't think they were
3 friends. The other -- the deputy sister that was on --
4 that had worked on the ward a long time and was on duty
5 the day Marion died said that she knew that they were
6 friends. But, again, I don't understand why her key
7 worker wouldn't have known they were friends. So -- but
8 it was very important to Marion because, as I say, this
9 was a kind of new experience for her, that she could
10 just quite easily make friends and get on with people.
11 And these were other women that were in the same boat as
12 her and they were in this sort of specialist provision
13 for years. This wasn't just a sort of assessment mental
14 health ward, with people coming in and out. They were
15 living together for years.

16 **Q.** Then on 2 March, you had a call with Marion where she
17 told you that Patient C had gone; is that right?

18 **A.** Yeah, I couldn't remember in my original statement to
19 the inquest the exact day Marion had told me but I know
20 that she had told me and she sounded very gutted about
21 it, I have to say.

22 **Q.** Yes.

23 **A.** And but the investigation report said that Patient C had
24 moved two weeks before.

25 **Q.** Ah.

1 **A.** Now, I kind of knew that didn't ring true with me. But
2 that's what staff told the investigators, apparently,
3 and that's what was there. It wasn't until the actual
4 inquest and in evidence, that EPUT were made to find out
5 the actual date --

6 **Q.** Yes.

7 **A.** -- which I think was quite hard for them because they
8 don't really seem to record these things.

9 **Q.** Yes.

10 **A.** And that was -- it was 2 March, two days before Marion
11 died. Marion did know that the plan for this patient
12 was that she was going to be discharged before Marion,
13 so she knew that, but it's their policy, obviously,
14 confidentiality, to not tell anyone.

15 **Q.** Yes.

16 **A.** It's like in the morning you wake up, "You're moving
17 today", and the first thing that your flatmate finds out
18 is that that's when you're moving. And I think at
19 another time it might not have affected Marion so much
20 but I think it was in the context of all these other
21 changes, and the fact that they were in this seemingly
22 never-ending lockdown that was always about to end but
23 then never did. Yeah.

24 **Q.** Do you think that's something that should have been
25 noted somewhere in terms of increasing Marion's risk or

1 her vulnerability at that time?

2 **A.** I think so because reading about her fear of abandonment
3 was one of the issues that was kind of involved in her
4 stabbing her partner in 2018.

5 **Q.** Yes.

6 **A.** Because their relationship status had changed and Marion
7 had reacted to that. So that was known to be fear of
8 abandonment and it's one of the symptoms of emotionally
9 unstable personality disorder, as I understand it.

10 **Q.** Yes, and you quote from Dr B's addendum report where he
11 said:

12 "... series of self-harming behaviours to relief
13 inner tension, extreme fear of rejection and
14 abandonment."

15 So it was part of the concern.

16 **A.** Mm.

17 **Q.** Moving then to another aspect of the changes that were
18 occurring, you describe Marion being told on 1 March
19 that she would have a Jersey court hearing on 4 March to
20 review her care as part of the six-monthly reviews?

21 **A.** Yeah.

22 **Q.** Then on 3 March, the day before Marion died, she was
23 informed that that hearing had been moved back to the
24 end of the month; is that right?

25 **A.** Yes. I think she spoke to her solicitor about it and

1 the staff, and the staff were sort of on to that change
2 they did recognise that as a change that may cause
3 Marion stress and they did check up with her about that
4 change. And although Marion seemed okay about it,
5 I think it did -- because she was coming kind of close
6 to discharge, which was due to be around
7 August/September, you know, obviously decisions were
8 going to be made. So I guess that there was maybe more
9 high stakes. The dates had been changed in the past,
10 and she'd sort of been okay about it, I think, but
11 I think -- what's being okay on the surface and what
12 Marion understood because she didn't have the
13 problem-solving skills.

14 **Q.** Yes.

15 **A.** And, again, that wasn't something I knew about until
16 I've read the reports, and it isn't in any of the, you
17 know, reports that have been done at Brockfield as
18 a risk factor. So how we interpret being told something
19 and how she actually experienced it are probably two
20 different things.

21 **Q.** So problems with problem solving were identified by Dr B
22 and Ms C?

23 **A.** Yeah.

24 **Q.** But from your reading of the material, that's not
25 something that made its way --

1 **A.** Features.

2 **Q.** -- into the ongoing record of her risk profile?

3 **A.** Yeah, because it really helped hearing that information
4 because I thought, well, something that sort of seems
5 run-of-the-mill to me, she doesn't see it in the same
6 way, you know, because she can't grapple with the
7 problem. She panics or it's stressful for her, in a way
8 that other people would think, "Oh, yeah, that's" -- but
9 she doesn't -- she just doesn't experience that in the
10 same way. So I think that would have been quite
11 a helpful -- well, it would have been a helpful thing
12 for staff to have been aware of and I don't get any
13 sense, from what I've read, that they were aware of
14 that.

15 **Q.** Another aspect of potentially destabilising elements,
16 you point to arrangements being made around that time to
17 have Marion assessed in preparation for her discharge
18 and to secure her a suitable place to live, and you
19 mentioned earlier that her key worker had spoken to
20 Marion about supported accommodation and on 11 February,
21 is it right, that Marion gave permission for that
22 information to be shared with you?

23 **A.** Yeah, it was the social worker that did that, not the
24 key worker.

25 **Q.** The social worker?

1 **A.** Yeah, the social worker arranges those sort of, you
2 know, assessments.

3 **Q.** By 3 March, the day before Marion died, had any contact
4 been made with you?

5 **A.** No, it hadn't.

6 **Q.** So at this point, Marion is facing a potentially
7 stressful assessment with an accommodation provider that
8 was booked in for 8 March?

9 **A.** Yeah, which I was going to see her on the 7th, so
10 I probably would have talked to her about it then.
11 Yeah. I knew it was booked on the 8th because it had
12 been booked in at ward round, which I think was on the
13 1st, possibly.

14 **Q.** As far as you're aware, building up to and in advance of
15 4 March, was there anything to suggest that Marion's
16 mental state or behaviour had changed during those
17 weeks?

18 **A.** I think she just -- when I last spoke to her on the
19 Thursday night, I think there was a bit of a -- I was
20 a bit worried because she seemed to have given up
21 reading, she just seemed a bit fed up and she just said,
22 "I've just been laying on my bed", like, not listening
23 to the radio, just laying there, and I thought that
24 doesn't sound very healthy. But I just thought, well,
25 I'm seeing her on Monday, you know, the lockdown is

1 going to end tomorrow, she'll be out to Wickford doing
2 her shopping, and everything will just return to normal,
3 you know. I just thought -- and I didn't know
4 everything I know now --

5 Q. Yes.

6 A. -- you know, about the risk factors.

7 Q. So at this point, from your understanding, there are
8 some staff members that are expecting, if she is
9 relapsing, for there to be psychosis. There are some
10 who are expecting her to remain calm.

11 A. *(Witness nodded)*

12 Q. There's general confusion.

13 A. Mm.

14 Q. But, from your perspective, there wasn't anything in
15 particular at that point which would have pointed to
16 a relapse?

17 A. No, but I knew that it was a lot of change for her.

18 Q. Yes.

19 A. But I was kind of assuming that staff recognised those
20 changes. I just assumed that they would think this is
21 a change, that's a change, that's a change. But,
22 obviously, I found out subsequently they weren't
23 counting a lot of the things I was counting as changes
24 as changes.

25 Q. You refer in your statement to a piece of homework that

1 Marion completed for Dr D in her self-forgiveness
2 handbook on 3 March --

3 **A.** Mm.

4 **Q.** -- which was uncharacteristically brief?

5 **A.** Mm.

6 **Q.** And that he therefore arranged an appointment to discuss
7 her answers on 8 March; is that right?

8 **A.** Yes.

9 **Q.** But, beyond that, that was the only thing, as far as you
10 can see --

11 **A.** Yeah.

12 **Q.** -- that sort of demonstrated a change in her behaviour?

13 **A.** Yeah, other than, as I say, not -- just seeming to be,
14 you know, disinterested in other things, I guess. That
15 was the only thing.

16 **Q.** Yes. Then on 3 March there was also a risk profile form
17 completed for Marion.

18 **A.** Mm.

19 **Q.** What is your view as to the sufficiency and accuracy of
20 that form, knowing what you know now?

21 **A.** Well, it just wasn't accurate because it was saying, you
22 know, impulsive -- history of impulsive behaviour and
23 they'd written, "No". I can't remember. There was
24 something else that was blatantly wrong.

25 **Q.** I think you say, "Early warning signs of relapses

1 listed"?

2 **A.** Yeah.

3 **Q.** And it's marked "Yes"?

4 **A.** Yes, and it's obviously a no for Marion.

5 **Q.** Then, as you say, impulse control and impulsivity as
6 a historical risk factor is also marked "no", when it
7 should have been marked "yes"?

8 **A.** Mm, mm, yeah.

9 **Q.** So would it be fair to say, in your mind, that, had it
10 been an effective and accurate risk profile --

11 **A.** Mm.

12 **Q.** -- it may have been an opportunity at which it could
13 take stock --

14 **A.** It may have been. It would have given a better chance,
15 I think, and for staff to actually know, you know,
16 Marion's history well.

17 **Q.** Then turning to the conclusions at the inquest, it's
18 right, you refer to the jury concluding that:

19 "Given what was known by clinicians and staff on
20 Aurora Ward with regard to Marion's capacity
21 historically to suffer sudden and extreme deterioration
22 in her mental state" --

23 **A.** Mm, mm.

24 **Q.** -- "leading her to inflict extreme violence against
25 herself or others, insufficient consideration was given

1 to the known potential triggers for such
2 deterioration" --

3 **A.** Mm.

4 **Q.** -- "such as fear of abandonment and sudden changes to
5 plans or routines."

6 **A.** Yeah.

7 **Q.** This is another thing that is said to be possibly
8 contributory?

9 **A.** Yeah, yeah. I think the mistake that was made over the
10 date she was meeting the supported housing, having that
11 assessment was really probably the last straw for her
12 because she'd been expecting it to be the following
13 week --

14 **Q.** Yes.

15 **A.** -- and then the day that they were then being told that
16 lockdown was probably going to end, was -- she was
17 suddenly having this assessment at 2.00.

18 **Q.** So this is turning to 4 March itself?

19 **A.** Mm, sorry.

20 **Q.** No, that's extremely helpful. At that point, she, in
21 her mind, is expecting to have the assessment meeting
22 a few days away on the 8th?

23 **A.** Yeah.

24 **Q.** At the morning meeting, do I understand it correctly,
25 she's then told that, in fact --

1 **A.** It's that day at 2.00 --

2 **Q.** -- that meeting is happening that day at 2.00?

3 **A.** Even though the lockdown hadn't ended and they weren't

4 going to be told if the lockdown had ended until 2.30.

5 So how this was actually going to happen; again, it was

6 just common sense had gone out the window.

7 **Q.** So there are two members of staff at this point --

8 **A.** Mm.

9 **Q.** -- looking after the patients on --

10 **A.** Mm.

11 **Q.** -- on Aurora Ward. Do you know how many patients there

12 would have been at this stage?

13 **A.** I think there was nine but the difference was they were

14 all there and the other difference was the staff were

15 cooking meals, three meals -- you know, two meals a day,

16 which wasn't normally what they did, and normally

17 everyone was out. You know, some people were out, for

18 long periods. So suddenly it was two members of staff

19 sort of doing everything, and everyone was there, and

20 they were having to cook meals and take their breaks,

21 et cetera.

22 **Q.** The morning meeting happens. Are both staff present?

23 **A.** No, just one staff member, the agent -- I think it was

24 an agency member that had worked quite a lot at

25 Brockfield House. The deputy sister had gone off to

1 a meeting, so --

2 Q. So there's one member of staff conducting the meeting
3 and is it right that the information that she gave about
4 Marion's meeting with the accommodation was wrong --

5 A. Mm.

6 Q. -- that she'd just got the date wrong; is that right?

7 A. The deputy sister said at the inquest -- the
8 investigation couldn't find where this -- why this had
9 been recorded wrongly but the deputy sister said at the
10 inquest that it was her that had recorded it wrongly in
11 the diary and she didn't know why she'd done that. But
12 if they -- they would have known what Marion was like.
13 She was a stickler. She had a diary. She would know
14 dates and times more than the staff would. She would
15 be, you know, saying, "Well, what's" -- you know, "I've
16 got this today at this time". She wasn't someone that
17 made mistakes. So if she was going to the office to
18 say, "Are you sure about this?", which she did
19 apparently twice that morning, they should have taken --
20 to me, if they'd -- you know, knowing her, they should
21 have taken notice of that, and double checked it, by
22 calling the social worker. But no one did. And no one
23 saw her go into the office twice as a sign of anxiety.
24 You know, that -- they knew that she wasn't expecting it
25 that day, but they didn't respond to that. They just

1 said, "Oh, it's at 2.00", even though they were still in
2 lockdown.

3 **Q.** At the meeting, is it right that they'd also said they
4 were expecting an update on lockdown or they would
5 end --

6 **A.** At 2.30.

7 **Q.** At 2.30?

8 **A.** So the coroner actually said to them, you know, "Did you
9 think to contact the staff that were coming to assess
10 Marion?" And they were like, "No".

11 They just weren't -- they just weren't thinking,
12 I don't think. They just weren't thinking.

13 **Q.** And you've described a lot more expectations and
14 responsibilities, perhaps, for these staff at this point
15 in time --

16 **A.** Yeah.

17 **Q.** -- whilst all those --

18 **A.** Yeah.

19 **Q.** -- patients are there rather than out?

20 **A.** Mm.

21 **Q.** What is your view as to whether this was as a result of
22 additional pressures or a general approach?

23 **A.** I don't really know, but I think there were additional
24 pressures on staff, because they kept the same staffing
25 numbers but there was a lot more for staff to do and

1 that didn't seem to be taken into account.

2 **Q.** What is your view as to the impact that this erroneous
3 information and the failure to then check whether she
4 had the date right had on Marion?

5 **A.** Well, I think she just -- it was the final straw and
6 I think she just panicked. I think she must -- you
7 know, she might not have shown it but I think, you know,
8 it was a shock to her. But also the other issue was
9 everyone was potentially going out into Wickford to do
10 their shopping and it was the end of lockdown but she
11 was, you know, bittersweet. She was having a meeting
12 about discharge but that meant she wasn't going to be
13 able to go out.

14 **Q.** Yes.

15 **A.** So it was, you know, it must have been -- I think it
16 must have just been a shock to her and she just -- it
17 was just a panic, probably.

18 **Q.** Then at 11.15, Marion requested a large kitchen knife,
19 she told staff, to prepare her lunch. She was issued
20 with a knife with an 18-centimetre blade. Is it right
21 that that's the largest, as you understand it --

22 **A.** Yeah, and it was the dagger kind. It wasn't the rounded
23 tip, which was what they had available at the time.

24 **Q.** They just had the dagger kind available --

25 **A.** Yeah.

1 Q. -- there weren't safety knives?

2 A. No.

3 Q. You explain that the nurse, Ms F, gave evidence at the
4 inquest that, at the time of issuing the knife to
5 Marion, she was displaying a normal presentation. She
6 didn't detect any irritability or anger but that, in
7 fact, she had understood that Marion probably would be
8 calm before relapse; is that right?

9 A. Yeah, that's true.

10 Q. You comment in your statement that you were concerned
11 that there was no curiosity about why Marion needed
12 a knife. Can you say a bit more about that?

13 A. Well, because she didn't -- she wouldn't have had any
14 food to cook because staff were cooking all the meals
15 and she'd been -- I think there was one night she didn't
16 have the staff meal but she was having the staff meal
17 that they'd cooked.

18 **THE CHAIR:** What happened on the night she didn't have the
19 staff meal?

20 A. I don't know. I think she had something maybe out of
21 a tin. But the other thing -- this is a slight side
22 shift but when I read the Brockfield House CQC report of
23 2015, which it was rated as "Good", one of the points
24 they fell down on was that they weren't putting the
25 right date on food that was opened. So they were

1 sticklers for that. Anything that was out of date had
2 to go out and food had to be bought that was packaged,
3 so if you bought vegetables or fruit, it had to be
4 covered. It shouldn't just be loose. So -- they were
5 sticklers for that and yet the investigation report --
6 the police did not check after she died what food was
7 left and the investigators just said there were some
8 fresh vegetables left. But I was thinking they would
9 not have been everywhere, and certainly not by health
10 and safety standards.

11 **THE CHAIR:** Sorry, who said there wouldn't be some fresh
12 food available?

13 **A.** The investigators said that two weeks after they cleared
14 out -- after she died, they cleared out the fridge and
15 there were some vegetables in there that would have been
16 fresh at the time. But I really do query that, given
17 that her last shop was on 8 February and then staff
18 probably, you know, around a few days into lockdown,
19 bought about 10 or 12 items.

20 **MS LLOYD-OWEN:** So this is 4 March?

21 **A.** Yeah, this is sometime after.

22 **Q.** Yes, two weeks --

23 **A.** And staff are cooking meals, it's been decided because
24 people don't have food that staff are cooking meals. So
25 it -- again, it just doesn't add up. There's no

1 curiosity about it. Because it's -- because people can
2 ask for a knife and be given it, they can do it. They
3 can do it even at the end of a 16-day lockdown when
4 there is -- you know, it just is very odd and very
5 disappointing.

6 **Q.** Then on the knife signing-out sheet, you referred
7 already that, of those entries that are recorded, Marion
8 always returned the knife between 15 to 30 minutes
9 later?

10 **A.** Yeah.

11 **Q.** We know on this occasion that a member of staff went to
12 check on Marion sometime between 12.00 or 12.15; is that
13 right?

14 **A.** Yeah, it's very unclear, really, when it was. What they
15 say is they don't check on people to get the knives
16 back. They just do their hourly obs, which was what she
17 was on: hourly observations. So that's what they were
18 doing.

19 **Q.** So in terms of why the staff member went, you've
20 mentioned the hourly observations?

21 **A.** Yeah.

22 **Q.** You've also commented in your statement that that staff
23 member was planning to ask whether Marion wanted an
24 omelette?

25 **A.** Yeah, because she was making an omelette, they decided,

1 with some other patients, and so she was going to ask
2 Marion, forgetting that Marion had a knife because she
3 was supposed to be cooking her lunch. And again, this
4 is something the investigators just let stand as
5 a statement and didn't ask another question about.

6 **Q.** So to your mind, was there a lack of vigilance around
7 the approach taken to giving knives --

8 **A.** Yeah.

9 **Q.** -- and perhaps --

10 **A.** Complete lack of vigilance.

11 **Q.** -- a casual approach?

12 **A.** A very casual approach.

13 **Q.** Marion was tragically found in her bathroom at some
14 point between 12.00 and 12.15 --

15 **A.** Yeah.

16 **Q.** -- and the records, as you say, as to the exact timing
17 are unclear -- with several stab wounds, which she'd
18 inflicted using the knife that had been issued to her.

19 **A.** Yeah.

20 **Q.** You comment that there was a delay in the emergency
21 medical response to Marion due to confusion about the
22 type of emergency. Can you say a bit more about what
23 happened, as you understand it?

24 **A.** That was one thing that the investigation revealed.
25 I didn't know about it until they revealed. But

1 apparently the nurse that -- I think it was the deputy
2 sister that had found Marion had to do the pinpoint
3 alarm, which is their system, so it's either
4 a psychiatric emergency, which then calls the staff from
5 other wards who are kind of on duty to deal with someone
6 who's, you know, getting aggressive or whatever, and
7 then a medical emergency, which calls the duty doctor.
8 So the nurse is saying she did a medical emergency over
9 the radio, or whatever, the pinpoint alarm, but the --
10 for some reason at security or the reception, it was put
11 through as a psychiatric emergency.

12 So that caused a delay because there was confusion
13 over what kind of emergency it was.

14 **Q.** That report and investigation recognised that, in
15 Marion's case, it would be unlikely that her attending
16 sooner would have had an impact on the outcome for
17 Marion?

18 **A.** Yeah.

19 **Q.** But it may have done in other cases?

20 **A.** Yeah.

21 **Q.** You explain in your statement that you have further
22 concerns about the emergency response that followed.
23 Can you say a little bit about what other concerns you
24 had?

25 **A.** I think the -- I don't understand, if you see someone in

1 that situation, why someone cannot just phone an
2 ambulance.

3 **Q.** Yes.

4 **A.** Why are you shilly-shallying with pinpoint alarms? No
5 one at Brockfield House has got the equipment or skills
6 to save someone in that position. That is a clear
7 paramedic situation. But they went about their routine
8 and then I think it stated in the paramedic record that
9 it was like 20 -- I'm sorry, 12.17, I can't remember the
10 time, or 12.20 even.

11 **Q.** 12.17 to 12.20 --

12 **A.** Yeah, that the ambulance was actually called and
13 I think -- I recall that was the OT that called the
14 ambulance. So there didn't seem to be any sort of
15 system of, you know, someone, actually, calling an
16 ambulance when an ambulance was needed. It was kind of
17 you followed this procedure, whatever you saw before
18 you. And one of the -- you know, I appreciate what the
19 staff saw that day, no one should have to see. But, you
20 know, the person -- the deputy sister pulled the
21 pinpoint alarm and the other person went to get towels.

22 **Q.** So it was your impression that --

23 **A.** It was just inadequate.

24 **Q.** Yes.

25 **A.** And also, which again wasn't picked up by the coroner,

1 actually, but I think is in my statement, and it was in
2 the records that one staff member had mentioned, and the
3 paramedic had put it in there, or the police had put it
4 in their statement for the inquest, that it took five
5 minutes to open the toilet door.

6 **Q.** Yes, you have that in your statement?

7 **A.** But, again, you see, the investigation didn't mention
8 these things. You know, again, it was just taken --
9 they raised the medical emergency but, in the
10 investigation report it doesn't even say what time the
11 ambulance was called. Isn't that a key element of an
12 investigation report into a death?

13 **Q.** You also comment on Marion having been moved from the
14 toilet area into the corridor --

15 **A.** Mm.

16 **Q.** -- and also there being confusion as to whether the
17 defibrillator was shocking or not?

18 **A.** And, again, that was the investigators that raised that
19 because I think my understanding is, if there is no
20 signs of life, it won't shock.

21 **Q.** Yes.

22 **A.** That's, I think, from what I've read. But there was
23 confusion amongst staff as to whether it had shocked or
24 not and the next day, they met -- when the person was
25 completing whatever form needed to be completed and they

1 changed it to that it hadn't shocked, meaning that she
2 was deceased when they were trying to use it. So,
3 again, there was a lack of training in these sort of
4 emergencies. And I guess a lack of belief there could
5 be a medical emergency, maybe.

6 **Q.** Yes. I want to turn now to your concerns regarding your
7 contact with EPUT and the investigations that took place
8 following Marion's death, and you've talked through some
9 of this already. But, first of all, I understand from
10 your statement that at 1.00 pm on 4 March, so this is
11 obviously very shortly after staff have entered Marion's
12 room --

13 **A.** Mm.

14 **Q.** -- you received a call from Marion's social worker. Can
15 you say a bit about what she told you when you spoke to
16 her?

17 **A.** Yeah, I mean, as I say, I was pleased that she'd phoned
18 because I was going to talk to her about the
19 accommodation, ironically. And then she said, "Oh,
20 Marion's hurt herself. I'm not sure what's happening,
21 but, you know, I'll get back to you as soon as I know
22 more". And I just said to her, "It's this, you know",
23 swearword "lockdown", by which I meant all the -- and
24 I said there's been so many changes for Marion and
25 I explained that Patient C had been moved. She was

1 unaware of that.

2 **Q.** Yes.

3 **A.** So then she told me, I phoned my parents and let them
4 know, and I was just kind of packing my bag hoping that
5 she was in hospital.

6 **Q.** What was the impression you were left with as to whether
7 Marion was going to be in hospital and recovering or
8 whether something more serious had happened?

9 **A.** I didn't really know but, obviously, when Marion does
10 something, it's always quite serious. I did know that.

11 **Q.** Yes. You say that at about 2.30 you hadn't heard any
12 more information so you called the social worker --

13 **A.** Yeah.

14 **Q.** -- again. What happened then?

15 **A.** It just went to voicemail so, by this time, I was
16 getting quite emotional and worried.

17 **Q.** Yes, of course. You say that the next contact you had
18 was from Norfolk Police, who came --

19 **A.** Yeah.

20 **Q.** -- to your home at about 3.00 pm. Did they explain what
21 had happened?

22 **A.** No. I mean, I knew. When the police car pulled up,
23 I saw it and I just thought, she's died.

24 **Q.** You contacted Essex Police?

25 **A.** They didn't know -- she was the messenger that had been

1 asked by Essex Police to give me the news. So that
2 was -- and she was lovely. But she obviously didn't
3 know anything about the circumstances. She couldn't
4 give me any information. So she gave me the number for
5 Essex Police. She said, you know, someone should
6 phone -- "If you don't hear by a certain time, you know,
7 give them a ring", and I hadn't heard, so at 6.00
8 I phoned. But I had to just leave a message. And
9 I didn't actually hear from Essex Police until 9.00 pm
10 the following day.

11 **Q.** So 36 hours afterwards you hear from Essex Police?

12 **A.** Yeah.

13 **Q.** In the meantime, on 4 March at 9.00 pm, Marion's social
14 worker called you?

15 **A.** Yeah.

16 **Q.** Was she able to tell you any more?

17 **A.** Well, I don't think she -- I don't know. I think she
18 called me -- I'm a social worker; she's a social worker.
19 It wasn't part of any protocol. I think she just called
20 me because she probably felt bad, you know, and she just
21 said, you know, "Condolences", and I said, "Can you tell
22 me, you know, where Marion is?" And she said, "Oh,
23 I think she's at Broomfield Hospital", and then she told
24 me the name of the undertaker and she told me that the
25 chaplain from Brockfield House had gone in the ambulance

1 with Marion.

2 **Q.** Yes.

3 **A.** So that's what she told me but she didn't tell me what
4 had happened and it was actually -- I had to phone
5 the -- I phoned the undertaker the following day, the
6 duty undertaker on the Saturday afternoon, and he
7 actually got back to me and kind of told me what more
8 the situation was because no one had actually told me.

9 **Q.** Yes.

10 **A.** Confirmed she was at Broomfield Hospital and that, you
11 know, the coroner would be involved and she was going to
12 have an autopsy, and things like that. You know. So he
13 was actually -- this random person, was actually the
14 person that gave me the most time and information but it
15 was me that was having to find the information, even
16 though I had lost my sister. It wasn't provided to me
17 and I still don't know: should it be the police? Should
18 it be EPUT? You know, it's not clear to me and does the
19 same happen if somebody gets in a road traffic accident?
20 Do they have the same treatment? Or is it just when
21 people die in mental health institutions? I don't know,
22 because maybe they're worth a bit less than other
23 people.

24 **Q.** That's the impression that you --

25 **A.** Well, either that or it's a sense of, you know, "We

1 might have done something wrong, so, you know, we're not
2 going to talk about it". But all people actually want
3 is the facts of what's happened and where their loved
4 one is. You know, they might get shouted at a bit but,
5 you know, surely they are able to deal with that, if
6 somebody has lost someone. It's just very badly
7 managed. Very badly managed.

8 **Q.** You go on to refer in your statement to a memorial
9 service that was held at Brockfield House for Marion.
10 How did that come about?

11 **A.** That was -- I got a phone call, I think, from the social
12 worker, who said that the chaplain was going to be in
13 contact with me because they were organising this. And
14 I agreed with it and I think that was a good thing that,
15 you know, that they did because, obviously, Marion knew
16 so many people at Brockfield, so many patients, and
17 suddenly she was gone. And, you know, I think a lot of
18 people that were, you know, more unwell on a day-to-day
19 basis had really looked up to Marion and then, suddenly,
20 she'd done that. So, you know, that was managed well
21 and the chaplain liaised with me, and I attended, and
22 I sort of did a -- I read about Marion and they planted
23 a rose. So that was when I got to meet some of the
24 women that she'd known. So that was nice. So that was
25 dealt with well.

1 And then they arranged another day, I think it was
2 the same week, where I went to collect Marion's
3 possessions, and that was also dealt with well.
4 Everything was packed already. I got to see her room.
5 I met some of the staff. The chief executive and
6 someone else from specialist services was there in the
7 background. Obviously, cynically, I'm thinking, you
8 know, testing the waters of what my reaction was going
9 to be.

10 And, you know, they'd left her toiletries, and
11 I said they could go to other patients, mobile phone and
12 things. So that was dealt with well.

13 **Q.** Yes. Then much later in early November 2022, you
14 received a call from Marion's original social worker to
15 say that an envelope full of condolence cards had been
16 found in a drawer in an office.

17 **A.** Yeah.

18 **Q.** Those were condolence cards from patients?

19 **A.** From patients, yeah, to the family --

20 **Q.** For you?

21 **A.** -- to our family, yeah. So I arrived and I asked him to
22 send them to me. He asked if I wanted them and I said
23 yes. So I received them in November 2022.

24 **Q.** Then in terms of the investigation that followed, you
25 explain that on 21 March, you were notified by letter

1 from EPUT's patient safety incident management team that
2 they would be reviewing Marion's care?

3 **A.** Yeah.

4 **Q.** You were given contact details for a family liaison
5 officer. What was your view/impression of the
6 suitability of Ms H, who was the family liaison officer?

7 **A.** Well, I was -- she did tell me this: that she was the
8 manager of Marion's -- the line manager of Marion's
9 social worker at Brockfield House, which I thought was
10 slightly odd.

11 **Q.** Because of the conflict of interest?

12 **A.** I think so. But I think what the thinking -- the only
13 way I can describe it, the thinking was because I had
14 said no one was to blame because I was very conflicted
15 when Marion died because, obviously, knowing her
16 history, you know, there aren't many warning signs when
17 Marion does something.

18 **Q.** Yes.

19 **A.** So I understood that and I didn't, you know, kind of
20 want staff to feel bad and I was very conflicted about
21 that for quite a long time. And, obviously, I didn't
22 have all the information I have now. So I think it was
23 probably taken like, "Oh, well, there's not going to be
24 a problem with this. She's a social worker, let's give
25 her another social worker". You know, job done, sort of

1 thing.

2 **Q.** You received a booklet, *Information for Families*
3 *Following a Bereavement*, with the letter --

4 **A.** *(Witness nodded)*

5 **Q.** -- which talked about what you can expect if there's an
6 investigation?

7 **A.** Yeah.

8 **Q.** But you'd been told there was a review; is that right?

9 **A.** Yeah.

10 **Q.** So you didn't appreciate that the expectations --

11 **A.** Mm.

12 **Q.** -- for an investigation were ones that you could ask
13 for?

14 **A.** No.

15 **Q.** You asked the family liaison officer, once you had the
16 help of a senior case worker from INQUEST --

17 **A.** Mm.

18 **Q.** -- for details of the investigators; is that right? So
19 then you were liaising from then on, directly with the
20 investigators?

21 **A.** Yes, because I just found the family liaison officer.
22 She just wanted to have heart to hearts with me. She
23 didn't actually tell me really anything about what was
24 happening. And when I asked her to find out
25 information, she never really got back to me. So it

1 just -- I gave up, really, on her, and she didn't put
2 things -- she wouldn't email me. She would just phone
3 me. So I, you know, I just gave up, really, on her.

4 **Q.** You also outlined the delays that you experienced in
5 receiving the report. Can you say a little bit about
6 that process?

7 **A.** Yeah, I think the original investigator, probably it was
8 a little bit -- you know, she was trying to be helpful
9 and she said it would be July and that, you know, it
10 would be through all the various committees it needed to
11 go through by August 2022.

12 **Q.** Yes.

13 **A.** Then we had the pre-inquest review hearing and it wasn't
14 happening then. It was going to happen mid-October, was
15 the date given. Well, it's not a date, is it? It's
16 a general time. But then it still didn't arrive. No
17 explanation was forthcoming. I think by that time,
18 I then was getting a solicitor, which I hadn't had.
19 And, yeah, it just -- there was just no information.

20 And then I got a phone call on 21 December, four
21 days before Christmas, saying, "Oh, the report's done
22 now, it'll be being posted out to you", from the family
23 liaison officer. And I was thinking, "Why are you doing
24 this four days before Christmas?" You know, this is not
25 something I need now. I want the report but I don't

1 want it posted to me now.

2 **Q.** Did it arrive before Christmas?

3 **A.** It didn't arrive and I wasn't even at home; I was in
4 Jersey with my parents. You know, it didn't arrive
5 until I think 12 January, when I'd had to actually go
6 back to Jersey because (... redacted ...) So it -- they
7 didn't forewarn me. They said there'd been a delay but
8 they didn't actually say like, "We're posting it today".
9 Then I had to go through this rigmarole of getting
10 a password to get it via email because obviously
11 I wasn't at home to actually have access to it. So
12 there just wasn't the planning, you know, behind it.
13 And I wasn't kept up-to-date on it by anyone.

14 **Q.** You also comment on errors in the report and you talk
15 specifically about the accompanying cover letter --

16 **A.** Yeah.

17 **Q.** -- to the report, referring to you as the client who had
18 died?

19 **A.** Yes, it said, you know, "We've completed the
20 investigation into Karen's care", and they've just sent
21 that out, which, you know, by then, it was just another
22 thing, to be honest. It was just another thing.

23 **Q.** I think you mention hearing one further time from the
24 family liaison officer?

25 **A.** Yeah.

1 Q. When was that?

2 A. That was about a week or maybe two before the inquest.
3 Obviously, my thought is somebody had nudged her and
4 said, you know, "Have you been in contact with Marion's
5 sister about the inquest?" She hadn't, and she hadn't
6 kept in contact with me at all. And, you know, she
7 said, "Would you like me to support you at the inquest?"

8 That was bizarre. Of course I didn't want her to
9 support me. So, you know, again, the impression was not
10 good and they hadn't thought through that I may change
11 my mind or my view of things and, actually, I did need
12 someone independent because what if I had an issue with
13 the social worker?

14 Q. Yes.

15 A. Their line manager was the family -- there was just no
16 thought put into it, other than like, "She's the social
17 worker, you're a social worker", and that was, I think,
18 the level of thought.

19 Q. You then outlined the findings of the report. You
20 outline them in some detail in your statement, which
21 we've largely already covered.

22 A. Yeah.

23 Q. But beyond these specific findings, what was your view
24 as to the adequacy of the patient safety incident
25 investigation report and whether there were the gaps in

1 it?

2 **A.** Yeah, there were gaps. I mean, I was grateful that, you
3 know, the points about the medical psychiatric -- there
4 was bits that I found out from that that I wouldn't have
5 found out but then there was whole areas where, you
6 know, like with the omelette and the lunch, and the
7 issuing of the knife, that they just took at face value,
8 you know, and they didn't ask any more questions. The
9 questions I asked were answered, to some extent, but not
10 really delved into. It felt like there was always
11 another question to be asked but they only asked one
12 question, and then they just accepted the answer and
13 wrote it down. They didn't pick up the different
14 diagnosis. You know, they didn't pick up quite a few
15 issues.

16 They didn't even mention Marion's diagnoses and the
17 first thing they did when they gave evidence was mention
18 them because I think --

19 **Q.** This was at the inquest?

20 **A.** Yeah, because probably counsel had told them to because
21 it's a major gap in the report.

22 **Q.** Yes.

23 **A.** So it was a long report but -- and there were some
24 highlighted deficits in it but it was more the sort of
25 stuff -- procedural stuff that had gone wrong, you know,

1 and the issuing of knives and that there was no risk
2 assessment and that, you know, her risk assessment
3 wasn't up to date.

4 Things like the discharge planning, they didn't
5 really delve into. They didn't express an opinion that,
6 actually, it would have been helpful to have had, in her
7 particular case with her history, you know, they didn't
8 go to areas like that.

9 **Q.** Then you talk also about the delay in provision of
10 material by EPUT to you --

11 **A.** Yeah.

12 **Q.** -- and that you felt it was being drip fed as the
13 inquest --

14 **A.** Yeah, I mean, the investigators say they've read
15 everything, so you kind of think, well, it must be
16 there, then.

17 **Q.** Yes.

18 **A.** But, you know, it comes in dribs and drabs and, you
19 know, my statement was due in the April. Well, by that
20 time, I didn't have a lot of information. I only had
21 the sort of expert reports from when the, you know, the
22 court hearing that Marion was involved in. I only
23 really had that. I didn't have her records, you know,
24 a lot of other information. I did have the
25 investigation report but, yeah, it's -- yeah. I mean,

1 it's traumatic being told there's going to be a jury
2 inquest because you've never heard of it.

3 **Q.** Yes.

4 **A.** And then, you know, I wanted to be involved, and so you
5 have to get your head round a lot of information. But
6 it's very hard when -- to respond to it when you haven't
7 got all the information.

8 **Q.** One of the examples you give is the EPUT action plan,
9 which was produced by EPUT to explain to the coroner
10 that things that changed since Marion's death --

11 **A.** Yeah.

12 **Q.** -- and that was only shared during the inquest
13 hearing --

14 **A.** Yeah.

15 **Q.** -- and you felt that didn't give you much time to
16 consider it?

17 **A.** No, no.

18 **Q.** The inquest touching upon Marion's death was an
19 Article 2 jury inquest --

20 **A.** Yeah.

21 **Q.** -- in which the jury returned a narrative conclusion,
22 concluding that Marion Michel took her own life but were
23 unable to determine her intention at the time she did
24 so, and you set out at your paragraph 265 their
25 conclusions as to the omissions which possibly

1 contributed significantly to Marion's death --

2 **A.** Mm.

3 **Q.** -- all of which we've outlined, but those were: the
4 absence of a focused risk assessment with respect to
5 Marion having unsupervised access to knives, prior to
6 her transfer to Aurora Ward and following; inadequate
7 processes and poor controls around access to knives
8 increased this possibility; insufficient consideration
9 being given to the known triggers for deterioration; and
10 a missed opportunity for staff to consider the
11 cumulative effect of changes on Marion's health?

12 **A.** Yeah.

13 **Q.** Is there anything further you wish to say about those
14 conclusions?

15 **A.** No, the only thing that they didn't conclude was
16 possibly, significantly -- contribution was the Fuji
17 Ward bit.

18 **Q.** Yes.

19 **A.** Because, obviously, she was observed at all times.

20 **THE CHAIR:** The Fuji what?

21 **A.** The access to sharps on -- the knives on Fuji Ward
22 because she was always supervised.

23 **MS LLOYD-OWEN:** Yes.

24 **A.** So that, they didn't. So I think it was five out of six
25 that was put to them, they agreed, but the only one they

1 didn't agree was the Fuji Ward because she was always
2 supervised on the Fuji Ward.

3 Q. Yes, so is it right that they said there was an absence
4 of any further specific risk assessment of Marion --

5 A. Yeah.

6 Q. -- in respect of her supervised access to knives on Fuji
7 Ward but that, although they agreed with that, they
8 heard no evidence that this contributed to Marion's
9 death --

10 A. No, yeah.

11 Q. -- because there was that consistent supervision?

12 A. Yeah.

13 Q. So it didn't -- although it was that there wasn't that
14 risk assessment, it wasn't causative?

15 A. No.

16 Q. I want to turn now, finally, to the final part of your
17 statement which records your reflections and
18 recommendations and, in particular, at paragraph 276 you
19 set out a list of recommendations based on your personal
20 experience.

21 I'm going to ask if page 61, paragraph 276 can be
22 put on the screen.

23 Now, you set out a total of 12 recommendations. You
24 can see on the screen there in full the first three.
25 We've been through some of these earlier in your

1 evidence and I just want to ask whether, in relation to
2 those three, there's anything more you would like to say
3 about any of those recommendations?

4 **A.** I guess it's -- the overall thing is that I wasn't aware
5 of any of these things.

6 **Q.** Yes.

7 **A.** You know, it was assumption that she was there.
8 Obviously, I've said a lot of positive things about the
9 environment and some of what was on offer for her there,
10 but -- so the assumption was, you know, because you
11 weren't given any information, that all these things
12 were in place, but actually, they weren't. But you
13 weren't aware of it and, you know, things weren't shared
14 with you, really. There wasn't involvement in -- with
15 the family and I think the discharge planning, as well,
16 you know, was woefully inadequate for Marion.

17 **Q.** You say at the bottom of page 61 and on to page 62, you
18 recommend that discharge planning involve a clearer
19 framework of timescales, process and planning and that
20 families should be consulted more, and more involved
21 from an earlier stage in plans.

22 I think you've commented upon that. Is there
23 anything further you want to say about that?

24 **A.** Well, they're the support for the person going forward,
25 aren't they and it's going to, you know, be a big thing

1 in their lives, as well. So -- and with Marion's
2 history, any sort of change or move is -- and she hadn't
3 lived independently on her own; she'd lived with
4 a partner, for a long time. So there was a lot
5 involved, and they were aware that she hadn't really
6 thought that through. But they didn't share that. They
7 didn't explore that, or there's no evidence that they
8 did. And it just feels like you're getting towards
9 discharge, you've got a rough date and you're in the
10 sort of sausage machine, really: one size fits all.

11 **Q.** If we can go now to page 62, there are a further four
12 recommendations set out in full here.

13 **A.** Yeah.

14 **Q.** If you can just have a read of those and, if there's
15 anything further you wish to say about any of these
16 recommendations?

17 **A.** Yeah, I think a lot of things weren't recorded on -- you
18 know, the records every day. I appreciate they
19 shouldn't be writing things about people that -- for the
20 sake of it but the records every day were really just
21 read the same.

22 **Q.** Yes.

23 **A.** As did a lot of the ward rounds' reports and things: cut
24 and paste sort of style. And I think, just the
25 appreciation that for people -- like how many days had

1 this lockdown being going on, just to record that
2 because it wasn't very clear, like, when it started and
3 when it ended, for staff coming on duty, to know, "Oh,
4 you know, this is day 10". I remember when, you know,
5 in the height of the pandemic we were stuck inside how
6 that actually feels. I think that would just be a flag
7 up.

8 I think Marion, you know, was someone who had lived
9 a life. She'd had a lot of settled periods when nothing
10 had happened and, when she relapsed, it was serious and,
11 in fact, the professor that did the report about her
12 said the greatest risk to Marion on discharge was her
13 accidentally killing herself through self-harm.

14 So it had been recorded, but nobody seemed to be --
15 she was just this model patient. She was just this
16 model patient and that then just -- I think she was just
17 someone they didn't really need to worry about. And
18 she'd done so well, she was a success story, sort of
19 forgetting that she still could have risk factors and
20 that, you know, times of change were big times for her.
21 And the friendships -- I think, you know, I think that
22 was completely understated by staff: you know, the
23 importance of those to people on these kind of wards
24 where you're there for years.

25 **THE CHAIR:** Can I ask, at the time, and you've talked about

1 how she was a model patient who was sort of overlooked
2 and you've identified a lot of the triggers and the
3 things that clearly were affecting her --

4 **A.** Mm.

5 **THE CHAIR:** -- and the risks but, at the time, what was your
6 sense of the dangers Marion was in?

7 **A.** I think it was any change and transition, really,
8 I suppose, you know, I felt needed a bit more care and
9 attention. And I thought that was being done when Dr B
10 said, like, "You're having a two-week transition to
11 Aurora", I thought they were bearing that in mind. So
12 I think she needed more support.

13 **THE CHAIR:** But, at the time, did you foresee what might
14 happen?

15 **A.** No. No.

16 **THE CHAIR:** I see.

17 **A.** But I didn't know all that I know now either. They had
18 all that information about her.

19 **MS LLOYD-OWEN:** You mean, in terms of things like problem
20 solving difficulties and that sort of thing?

21 **A.** Yeah, yeah. I acknowledge that obviously all of
22 Marion's incidents were -- you know, the family didn't
23 see them coming and so, to a certain extent, who could
24 see them coming? I do acknowledge that. But I think,
25 at this stage, they did have the best chance to see it

1 coming. But it just seemed to be, you know, a number of
2 factors that just came together that sort of tipped it
3 over, really, into that -- which was very sad because
4 she was due to be discharged. So, you know ...

5 **Q.** I just want to make sure that, if we look at the bottom
6 of page 62, you've had an opportunity to comment on
7 that.

8 **A.** Yeah.

9 **Q.** That's a recommendation relating to staff training and
10 emergency response --

11 **A.** Yeah.

12 **Q.** -- including the use of defibrillators?

13 **A.** Yeah.

14 **Q.** Then, if we can go to page 63, there are a further three
15 recommendations which are set out in full --

16 **A.** Yeah.

17 **Q.** -- there?

18 **A.** It's just really, I think, investigations should be
19 independent because I felt it wasn't really thorough
20 enough.

21 **Q.** Yes.

22 **A.** And I don't -- I'll never know if they would have
23 actually contacted me. I contacted them and, therefore,
24 I gave my view, but they didn't contact me, the
25 investigators.

1 Q. When you made direct contact --

2 A. Yeah, with the --

3 Q. -- rather than through the family liaison officer?

4 A. Yes, and the INQUEST charity's national oversight
5 mechanism, I believe in that. And I think also that,
6 yeah, this is a problem across the country. And the
7 other issue which I haven't written here but is about
8 people placed out of area.

9 Q. Yes.

10 A. And, actually, you know, she had -- the Jersey courts
11 reviewed her progress every six months but she didn't
12 have a mental health worker for -- she had one at the
13 start and they came to a couple of the CPA meetings, and
14 then she didn't have anyone. And, in fact, it was the
15 court that had to pressure them to actually come up with
16 a name when it was coming up to the sort of discussions
17 about discharge.

18 So there was no -- and I've never had any contact
19 from Jersey mental health, never. And I haven't
20 actually had the energy to -- there's issues to address
21 there but I haven't had the energy to do that because
22 I've been focused on other things.

23 So, yeah, I think people out of area, it's kind of
24 out of sight, out of mind, you know, what do people that
25 could enquire about what policies are in place, what do

1 they actually do? They never spoke to Marion before
2 a CPA. They didn't attend most of the CPAs during
3 lockdown. So there was no sort of checks and balances
4 from an outside agency and, obviously, it was, you know,
5 they were -- Jersey was paying for this provision: the
6 specialist forensic provision. But -- and I'm sure it's
7 the same for other people placed out. It was just lucky
8 that I lived relatively near so that I could visit her,
9 as well --

10 **Q.** Yes.

11 **A.** -- because she would have been isolated.

12 **Q.** Karen, thank you so much for all of the evidence you've
13 given.

14 **A.** It's all right.

15 **Q.** I don't have any further questions for you at this
16 stage. Is there anything I've not covered --

17 **A.** No.

18 **Q.** -- that you'd like to address?

19 **A.** I just wanted to say one of the -- because Marion's
20 death wasn't included in the original dates and then
21 I found out about it and I thought it was very important
22 because this is a specialist service run by EPUT, and
23 that actually, you know, most people will have just been
24 in psychiatric hospitals that are coming to this
25 Inquiry, and I just thought it was important to raise

1 that specialist services also fall down, that they
2 provide. Albeit, you know, there are quite a few
3 positives about Brockfield House, I did feel that, but,
4 you know, scratch the surface and all was not completely
5 well, unfortunately.

6 **THE CHAIR:** We're very grateful to you for having brought it
7 to our attention.

8 **THE WITNESS:** Thank you.

9 **THE CHAIR:** So thank you.

10 **MS LLOYD-OWEN:** Chair, do you have any further questions?

11 **THE CHAIR:** I don't, no.

12 **MS LLOYD-OWEN:** Please can we have the photograph on screen.

13 We'll now show the photograph of your sister, Marion.

14 *(Photograph displayed)*

15 **THE CHAIR:** Thank you for that.

16 **MS LLOYD-OWEN:** Karen, we will now have a ten-minute break
17 to see if there are any further questions. If there
18 aren't any, that will concludes your evidence and you
19 are free to leave. Thank you again so much for the
20 evidence you have given today.

21 **THE CHAIR:** And if there are no questions, it's 10.00
22 tomorrow morning.

23 **MS LLOYD-OWEN:** 10.00, yes.

24 **(4.39 pm)**

25 **(A short break)**

1 (An announcement was made of no further questions)

2 (4.49 pm)

3 (The Inquiry adjourned until 10.00 am the following day)

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