Tuesday, 10 February 2026

(10.00 am)

(Proceedings delayed)

(10.21 am)

THE CHAIR: Ms Troup, good morning.

MS TROUP: Chair, good morning. We return now to family evidence and this morning we'll be hearing from Lisa Morris, the mother of Ben Morris, who died in 2008.

Before we hear any evidence, I would like to point again to the fact that today's evidence may in parts be distressing and difficult to listen to. For some, it may not be possible to sit through the entire session. Anyone in the hearing room is welcome to leave at any point.

I would like to remind people that emotional support is available for all of those who require it. We have support staff from Hestia, an experienced provider of emotional support, here today and for each day of this hearing. There is a private room downstairs where you can talk to Hestia support staff if you require emotional support at any point throughout the hearing. The Hestia support staff are wearing orange lanyards and scarves or, alternatively, you can speak to a member of the Inquiry team and we can put you in touch with Hestia. We are wearing purple coloured lanyards.

For those watching online, information about available emotional support can be found on the Lampard Inquiry website at lampardinquiry.org.uk and under the "Support" tab, which is near the top right-hand corner.

We want all those engaging with the Inquiry to feel safe and supported.

Could we have the witness sworn, please.

LISA MORRIS (sworn)

Questioned by MS TROUP

MS TROUP: Thank you. Can we start, could you give your full name, please?

A. Yeah, Lisa Anne Morris.

Q. Thank you. Lisa, you are the mother of Benjamin Morris who died at the Linden Centre aged just 20 --

A. *(The witness nodded)*

Q. -- on 28 December 2008?

A. Yes.

Q. You came before the Inquiry to give commemorative evidence in September 2024 at our hearing in Chelmsford --

A. Yeah.

Q. -- and you spoke about Ben and his life and the impact of his loss on you and your family?

A. *(The witness nodded)*

Q. You've now provided, in advance of this hearing,

a witness statement that's dated 16 January 2026 and, Lisa, you should have a printed copy in front of you.

A. Yes.

Q. Could I ask you, please, to turn -- it's a 59-page statement but if you could turn, please, to page 57 --

A. Yes.

Q. -- and just take a look at that page. There's 61 pages, actually, I'm so sorry. But if we could look, just for now, at page 57.

A. Yeah.

Q. That is the page where we see the date and that's also the page where you made a statement of truth and signed?

A. Yes.

Q. Lisa, to confirm, sitting here today, are you content that your statement is true and accurate?

A. Yes.

Q. Thank you. I want to start by going through some of the investigations that took place following Ben's death because, Lisa, I think it's right, isn't it, that there were a number of investigations and reports after Ben died?

A. Yes.

Q. So we're going to come back to some of those but, just taking them in order, an initial -- what's called a seven-day report was carried out by the Trust?

A. Yes.

Q. And that was published in January 2008?

A. Mm-hm.

Q. There was then also a full panel serious incident investigation and report --

A. *(The witness nodded)*

Q. -- and that was produced in July 2009?

A. Yeah.

Q. We're going to come back to that report, in particular, because I think, and you must tell me if I'm summarising correctly, that report made a very wide-ranging series of findings --

A. Yes.

Q. -- in relation to significant failings in Ben's care?

A. Yeah.

Q. Can I take it that you agree with those findings?

A. Yes, I do.

Q. Thank you.

There was also, in February 2011, an Article 2 inquest before a jury; is that right?

A. Yes.

Q. Then there followed two reports by the Parliamentary Health Services Ombudsman?

A. Yes.

Q. The first in 2017 was strictly related to Ben?

A. Yes.
Q. Then in 2019, a further report was published that addressed failings in Ben's care but also addressed failings in the care of Matthew Leahy?
A. Yes.
Q. Matthew died four years after Ben --
A. *(The witness nodded)*
Q. -- in the same unit, yes --
A. Yes.
Q. -- in November 2012.
A. Yes.
Q. Both of those reports again found significant failings, both in the care of Ben and in the care provided to Matthew Leahy?
A. Yes.
Q. Can I take it that you agree with the findings of those two reports also?
A. Yes, I do.
Q. Thank you. We know, Lisa, that Ben's death was also included in the Health and Safety Executive's prosecution of the Trust in 2020?
A. Yes.
Q. You were aware of that at the time and gave a victim impact statement in those proceedings?
A. Yes.

Q. For you, this has been running on for many years?
A. It has.
Q. In addition to all of those investigations and reports and prosecutions, there was some police involvement, is this right, in the immediate aftermath of Ben's death?
A. Police involvement -- from what sort of I read from all the information I have, they just sort of went to the hospital when Ben died and, again, from what I can read -- I haven't got any other evidence -- they got a few statements and put Ben's death down to a suicide.
Q. Yes.
A. I don't think there was ever an actual investigation, as such.
Q. I understand. That's your point, isn't it: there was no full police investigation?
A. Yes.
Q. That is a matter which, for you, remains outstanding?
A. Yes.
Q. So my understanding is that, in 2021, you wrote a very detailed letter to the Chief Constable of Essex Police --
A. Yes.
Q. -- and if I can summarise, in it, you set out a number of facts or areas of confusion about the circumstances of Ben's death --

A. Yes.
Q. -- and you made a formal request to Essex Police for his death to be investigated in full by police?
A. Yes.
Q. In summary, Lisa, the response you got was a no?
A. Yes.
Q. Is it fair for me to say that you remain wholly dissatisfied with that response?
A. Absolutely.
Q. As I understand it, to you, there remain issues and concerns and areas of conflict around what you know about the way in which Ben is said to have died that to you simply do not make sense?
A. *(The witness nodded)* Absolutely.
Q. Do not stack up?
A. No.
Q. And one of the things that you tell us in your witness statement is that, of all that has taken place, those are matters that continue to haunt you?
A. They do. Not knowing, I think, is worse than knowing.
Q. I understand. There was also a civil claim against the Trust, so civil proceedings were issued, and I want to note, because I know that it's extremely important to you, that the reason you issued civil proceedings against the Trust was not related in any way to a desire

for compensation on your part?

A. No, not at all, not at all. It seemed the only way to be able to get any statements from staff, the reports. They wasn't going to give them to me.

Q. Yes. So in fact, for you, it was an exercise in discovering more about what happened?

A. Yes.

Q. And civil proceedings allowed you to compel disclosure from the Trust?

A. Yes, from what I understand, you can't have one without the other. If you want to do that the compensation is part of that. You can't do it separate. So ...

Q. But you would have happily gone ahead without any involvement of any kind of financial compensation?

A. Oh, definitely.

Q. Because, to state the obvious, there is no compensation that can make up for your loss?

A. No, nothing, no.

Q. All right. Thank you. That's really useful to set out the investigations that have taken place and we'll come to those, in particular the full panel SI report and some of the PHSO findings because I think it's your view that those findings really were very important --

A. Yes.

Q. -- and that, although they came quite some time after

Ben had died, what they did was evidence the very fears you had had about the way in which he was being failed --

A. Yes.

Q. -- during his treatment?

A. Yeah.

Q. Lisa, also, to set matters in context, I think it's right, isn't it, that in Ben's life he had any one mental health inpatient stay?

A. Yes, that was his first ever stay in a mental health hospital.

Q. Yes. He was admitted to the Linden Centre and specifically to Galleywood Ward as a voluntary patient --

A. Yes.

Q. -- so not under section --

A. No.

Q. -- on 8 December 2008?

A. Yes.

Q. Knowing that he died on the 20th, it was therefore --

A. 28th.

Q. I'm so sorry, the 28th.

A. That's all right.

Q. It was therefore a 20-day stay?

A. Yes.

Q. Thank you. Can I take you back to Ben's childhood and I want to just cover with you the way in which you as a mother began to notice that it was possible that all was not well --

A. Mm-hm.

Q. -- with Ben. So if you want to follow it -- you don't need to but if you want to follow it, I'm looking at the first page of your witness statement --

A. Okay.

Q. -- and in particular at paragraph 4.

A. Yeah.

Q. There you tell us that what you noticed first of all, I think when he was quite young, is that he was hyperactive?

A. Yeah, he was, yeah, but I didn't sort of have any other children and I'd never been around young children either, our family didn't really have young children in it and he just seemed, yeah, extremely hyperactive.

Q. Yes, and, from there, you tell us that it began to become clear to you that he was struggling with day-to-day life?

A. Yeah.

Q. In what ways? Tell us a little more about that?

A. He was very impulsive.

Q. Yes.

A. I think, because that brought on frustration to him, he was quite angry.

Q. Yes.

A. It started disturbing his school life.

Q. Was that at primary school age or a little later?

A. Yes, primary school and he started getting bullied, as well, so that didn't help, and it just seemed to get worse as gradually time went on and then I had two more children and they wasn't hyperactive like Ben. So it --

Q. You could see the difference?

A. -- confirmed, yeah, that something wasn't quite right.

Q. There came a point where you, having those concerns, you took Ben to the GP to set out your concerns?

A. Yes.

Q. What was the GP's response?

A. Just that he was an angry child, a bit of a chip on his shoulder and a bit -- not very well behaved.

Q. Yes. What you say is that the GP didn't take your concerns seriously --

A. No.

Q. -- and, effectively, dismissed him as a "naughty child"?

A. Yes.

Q. Lisa, we'll come back to this but one of the things that you tell us is that, unfortunately, that was the beginning of what became quite a constant theme through

Ben's life --

A. *(The witness nodded)*

Q. -- of his very serious mental health issues being dismissed as bad behaviour?

A. Yes.

Q. In August 2005, Ben did have a psychiatric assessment and was given a potential diagnosis of ADHD, yes?

A. Yes.

Q. Then two years later, when he was 18, he was referred by his GP for anger management?

A. Yes.

Q. At that time, you've noted in your witness statement some of the observations that were made during the assessment. This is in July 2007.

A. Mm-hm.

Q. I think your view is that there was a very clear indication there of serious emerging mental health problems --

A. Yes.

Q. -- because, if we look at it -- if you want to, Lisa, I'm on page 2 -- what has been recorded is that Ben stated, during that assessment, that he has zero concentration span, cannot follow conversations, often doesn't understand what people are saying to him and he made reference to having three personalities?

A. Yes.

Q. So there was then some suggestion -- what's recorded is a "differential diagnosis is that of paranoid personality disorder"?

A. *(The witness nodded)*

Q. That was never given as a formal diagnosis; is that right?

A. No, no. All just suggestions, all just maybes.

Q. Yes, and, in fact, I think it is the case that, at no stage during Ben's life, was he given a settled or definitive diagnosis --

A. No.

Q. -- other than ADHD?

A. Yeah. Yeah, I mean, the doctor then was pretty sure it was ADHD but I'm not sure if it was still a proper diagnosis.

Q. Yes. In January 2008, Ben was referred to a psychiatrist and, looking at page 3 and paragraph 14 of your witness statement, again, there's suggestions of certain diagnoses?

A. *(The witness nodded)*

Q. There's nothing definitive?

A. No.

Q. So what was recorded at that time were "some features of an emotionally unstable personality of the impulsive

type"?

A. *(The witness nodded)*

Q. But "insufficient information to confirm"?

A. *(The witness nodded)*

Q. What we know from the records, and I think in fact you knew at the time, because Ben was 18, is that that psychiatrist started treatment with a drug called carbamazepine?

A. Yes.

Q. You understand that to be effectively an anticonvulsant that can be used as a mood stabiliser?

A. Yes.

Q. But it was also at about that time that the behaviours you've described began to draw Ben to the attention of police?

A. Yes.

Q. He was, by then, an adult?

A. Yes.

Q. In March 2008, the same psychiatrist who had seen Ben in January 2008 and given a sort of suggested possible diagnosis, three months later was asked to make a report for the Magistrates' Court --

A. Yes --

Q. -- in relation to criminal proceedings, and felt able, based on the same January assessment, to give a slightly

different interpretation?

A. Yes.

Q. To you that seems very confusing; is that fair?

A. It wasn't so much to me. This is what -- it just made Ben worse because he had then -- so by the time he died he had a possibility of several different things wrong with him but nothing was confirmed.

Q. Yes.

A. So no medication was given to help him control it and it just made him worse. It frustrated him so much.

Q. Of course.

A. He just wanted to know what was wrong with him.

Q. Yes. As far as you are aware, we're now in January and March 2008, but, at no stage in his young life, as far as you are aware, both from the time and having looked through all of the records, did anyone identify the baseline cause of his symptoms?

A. No.

Q. By early April 2008, Ben was unwell enough that you took him to A&E?

A. Yes.

Q. If you want to look at it again, Lisa, I'm at the top of page 4.

A. Yes.

Q. You tell us there that the staff at A&E were far from

empathetic?

A. Yes.

Q. What do you remember about that? Tell us how Ben was at the time?

A. He was actually -- in the end -- he tried to explain how he was feeling to them and he didn't really seem to get a lot of understanding or, what shall I say? Not sympathy: compassion.

Q. Yes.

A. He ended up actually sitting on the floor with his legs crossed, smashing his head against the wall.

Q. In the A&E department?

A. Yes, and he was escorted out by security and police.

Q. Yes. He was actively asking to be admitted at that time?

A. I don't think you could show it much more that you need help.

Q. Yes. Was he overtly expressing a desire to harm himself at the time?

A. No, not that I can remember, no.

THE CHAIR: But he was saying he wanted to be admitted?

A. Yes, he wanted desperate help.

MS TROUP: To you, I think it was very clear that he needed it?

A. Yes.

Q. In fact, he was escorted out of A&E and the outcome of it was a crisis team follow-up?

A. *(The witness nodded)* Yes. I mean, it almost made him want to give up trying to get help. He said it used to make him feel a bit stupid, really, going to ask for help and then just being treated in that way.

Q. Yes. On 9 October 2008, again, recognising himself that he was desperately unwell and needed help, he went to A&E, I think this time with his grandmother?

A. Yes.

Q. You know from the records that he was seen by a crisis team staff member --

A. Yes.

Q. -- on that date. Looking again at page 4 and paragraph 20 of your witness statement, what is recorded there are suicidal thoughts?

A. Yes.

Q. Paranoia and nightmares?

A. *(The witness nodded)*

Q. Sees himself in a coffin?

A. *(The witness nodded)*

Q. And paranoia and visual hallucinations?

A. *(The witness nodded)*

Q. Again, he was sent home --

A. *(The witness nodded)*

Q. -- and was seen the next day at his grandmother's house by a psychiatrist?

A. Yes.

Q. That psychiatrist -- so we're now on 10 October 2008 -- recorded that -- you were present, I think --

A. Yes.

Q. -- for that assessment?

A. Yes.

Q. And the psychiatrist recorded that both you and Ben were very keen that he find help immediately?

A. Yes.

Q. That psychiatrist also recorded that you both believed and were expressing that, without help, he was at high risk of hurting himself or even ending his life?

A. Yes.

Q. He was referred to a local crisis mental health team --

A. *(The witness nodded)*

Q. -- and had two appointments there --

A. *(The witness nodded)*

Q. -- or through that team in late October and mid-November 2008?

A. Yes.

Q. It was then that he received a formal diagnosis of ADHD?

A. Yeah.

Q. Tell us about the effect of receiving that formal

diagnosis?

A. He actually had tears running down his face. I think he'd waited so long and he said to finally get that diagnosis, it just gave him reassurance that he perhaps wasn't going to be like this forever. He perhaps could take some medication or some therapies, anything to help him control what his brain was doing and saying.

Q. So is it right for me to say that they were tears of relief?

A. Yes, absolutely.

Q. One of the things, at the time of that diagnosis, that happened, is that the psychiatrist also expressed the view that temporal lobe epilepsy might also be a factor?

A. Yes, because he would have kind of like a blackout. He could do something and then he'd say, "Ooh, who done that?"

"Well, you did, Ben". And he wouldn't remember. So he was --

Q. Had that been going on --

A. -- awake but --

Q. Not there?

A. Yeah.

Q. I understand. So, for that reason, because the psychiatrist had the view that that type of epilepsy might be a factor --

A. Yeah.
Q. -- he ordered an EEG, which was carried out?
A. But the first part of it was carried out, yeah.
Q. Tell us, so what happened about the second part?
A. So he had all of the brain scan and that come back, I think, to be all normal. Nothing was found.
Q. Yes.
A. So then the doctor decided to do one where he would be sleep deprived before he had it done, but that wasn't booked in until the January.
Q. Yes. So the first part -- the first sort of normal EEG having been returned as "normal", effectively --
A. Yes.
Q. -- the psychiatrist ordered for a more specialised sleep-deprived EEG to be carried out?
A. Yes.
Q. I think, in fact, that appointment was made for the 8 January 2009?
A. Yes.
Q. But, as you understand it, the advice was that treatment should not begin for ADHD until that more specialised EEG had been carried out?
A. Yes, because the results of the E -- what are they called, ECG?
Q. Yes, EEG?

A. Yes, the result of that would then be depending on what medication he would be put on for the ADHD and the temporal lobe epilepsy.

Q. Yes. And, in fact -- exactly. What the doctor recorded at the time, and this is in the quote that you've put in at the top of page 6 of your witness statement:

"I will not start treatment for ADHD unless and until I am fairly clear about the status of his possible temporal lobe epilepsy."

A. Yes.

Q. So that's where things were left?

A. Yes.

Q. We then come to early December 2008 and, in summary, as I understand it, you were not at home, and Ben broke into your flat --

A. Yes.

Q. -- contacted you, and made a number of threats?

A. Yes.

Q. You, knowing that he was very unwell, felt you had no choice but to contact police?

A. Yes, unfortunately.

Q. When you did so, you made what I understand from your witness statement to be fairly desperate efforts to explain to police that your son was unwell --

A. Yes.

Q. -- and needed care and treatment?

A. Yes.

Q. But you do not feel that that was received or listened to?

A. No.

THE CHAIR: Where was Ben living at that stage?

A. He was actually temporarily staying with me. He had a flat in Harlow. I think in the statements it says Hounslow but it was Harlow.

THE CHAIR: It does.

A. And he had temporarily come to stay with me so I could get him into our medical --

THE CHAIR: Practice, yeah.

A. Yeah, he wasn't getting really anywhere with Harlow. So temporarily staying with me.

THE CHAIR: Thank you.

MS TROUP: Police released him and then later, as I understand it, he -- Ben rang his grandmother from a train station --

A. Yeah.

Q. -- and sounded extremely unwell?

A. Yeah.

Q. On that occasion, police attended and did appear, to you, to understand that he needed assistance?

A. Yes.

Q. They took him to A&E?

A. Yes.

Q. From there, in the early hours, very early hours of 8 December, Ben was admitted to Galleywood at the Linden Centre?

A. Yes.

Q. Now, you were aware of that at the time, and is it right for me to say that, throughout those 20 days, you visited Ben at the Linden Centre?

A. Yes, yes.

Q. How often was that, Lisa?

A. We went quite a few times.

Q. Yes, so --

A. Um ...

Q. Just vaguely.

A. Seven, eight, nine times?

Q. Yes.

A. And if I didn't go to visit then, on the phone all day every day.

Q. Yes.

A. Either to me or his ex-partner or to my mum.

Q. Yes.

A. I think just because he was so bored. There was nothing to do other than to chat and -- yeah.

Q. He had a loving supportive family?

A. Yes.

Q. So he leaned on you all during that time --

A. Yes.

Q. -- and, as I understand it, he really was on the phone to one or other of you for a great deal of the time that he was there?

A. Yeah, he was.

Q. That, of course, also means that you had a very good sense of how he was doing --

A. Yes.

Q. -- because you were speaking to him or seeing him so regularly?

A. Yes.

Q. When Ben was admitted, one of the things you tell us in your witness statement is that, on his admission assessment, he reported suicidal intentions?

A. Yes.

Q. He said very clearly to the clinicians assessing him that he would kill himself or others if he was not given any help?

A. Yes.

Q. He reported that he had been hearing voices and having suicidal thoughts for about four years --

A. Yes.

Q. -- and that, on a scale from 1 to 10, of 1 not being

suicidal at all and 10 being very suicidal, at that time he rated himself at 9?

A. Yes.

Q. What appears to have happened is that, despite the fact that, as we're now in early December 2008 and the more specialised ECG, the sleep deprived version, had not yet been carried out --

A. No.

Q. -- nonetheless, clinicians at the Linden Centre decided to start medication for Ben's ADHD?

A. Yes.

Q. So he was started immediately on 40 milligrams of a drug called atomoxetine?

A. Yes.

Q. We're going to come to this, but the Trust's own Serious Incident Report is heavily critical, not necessarily of the dosage that was prescribed but of the way in which that drug was prescribed and the monitoring of it thereafter?

A. Yes.

Q. We'll come to it now actually. What you have learned from that report is that the doctor who took the decision to prescribe that medication for Ben's ADHD did not take steps to consult any specialist colleagues who were specialist in the treatment of ADHD; is that right?

A. Yes, and according to the NICE guidelines -- is it --

Q. Yes.

A. -- yeah, they're meant to consult with someone who's specialised in ADHD before prescribing that particular drug.

Q. The other point that is noted in the Serious Incident Report is that the psychiatrist who prescribed that medication acknowledged, when he was interviewed, that it was possible that nursing staff on the Linden Centre, who were responsible for the day-to-day care of your son, were not made fully aware, either of the purpose of his admission or the precautions that would be required, he having been prescribed that drug?

A. Yes.

Q. What is your understanding from those reports about why that matters and why he should have been monitored closely once it had been prescribed?

A. Well, atomoxetine is meant to be highly side effect suicidal.

Q. Yes.

A. So not only has he been put on a drug that could cause him to feel like that, he was also saying it in the hospital, as well, and no -- one member of staff possibly but the others didn't really seem to care.

Q. To care about what, in particular?

A. Well, his behaviour, the way -- you know, the way he would be -- his behaviours just seemed to again be put down to -- not naughtiness, he was a bit old for that then: bad behaviour.

Q. Yes.

A. He just seemed to be classed as someone that was angry and not very well behaved --

Q. Yes.

A. -- rather than perhaps what was going on with not now just his illness but what the medication was doing to him as well, because it wasn't just that that he was prescribed. He had the lorazepam, the sleeping pills.

Q. Yes.

A. What was that all doing to him.

THE CHAIR: So they treated him as if he had a bad character?

A. Yes, whereas most people I've met that suffer with their mental health, that's quite a lot of -- quite a lot of people like that can become very frustrated and very -- come across as angry. They're not going to hurt anyone but -- my daughter works with people like that and they swear a lot and they might kick the skirting boards and -- but it's all very accepted where my daughter works, whereas where Ben was, it was quite the opposite, and not accepted at all -- at all.

MS TROUP: Yes. I think one of your points is that, rather than try to establish what might be causing the agitation or signs of aggressive behaviour, as it was described, staff simply reacted to aggression as though it was almost sort of evidence -- we'll come to this later -- but almost sort of evidence of criminality or some sort of bad character?

A. Yes, yes.

Q. One of the things that the panel carrying out the Serious Incident Report discovered is that, although the psychiatrist who'd prescribed atomoxetine said that he had had a discussion with other staff about that, neither Ben's key worker nor the ward manager on Galleywood had any awareness as to the potential side effects of that medication?

A. Apparently not.

Q. And therefore nobody was monitoring for those?

A. Exactly.

Q. One of the things you say, going back to the evidence you've just given us about how Ben's behaviour was treated, is that in your analysis of the observations and day-to-day notes from his care, what appears to be recorded principally are observations about him being difficult or demanding --

A. Yes.

Q. -- as well as really very sort of basic observations about location, "He's in the corridor" --

A. Yes.

Q. -- or "He's in his room"?

A. Yes.

Q. What appears to you to be crushingly absent are any observations about what is actually going on for him?

A. I don't think -- I don't think anyone asked him, really, ever, of -- again, I think, apart from one member of staff, she had a nice conversation with him and he really opened up to her. But, other than that, I just -- yeah, perhaps -- yeah, it seemed like perhaps he was in, like, an alien costume and they just didn't want to go near him, let alone talk to him or try and find out who Ben was, you know, what's going on or -- there doesn't seem to be any of that at all.

Q. Yes. So if we look, Lisa, at page 10 of your witness statement, and if you look with me, please, at paragraph 39, this is a section where you're explaining what you've just explained: that the majority of staff appeared to have a very negative sense of Ben and of his behaviour?

A. Yes.

Q. But you also say there that it appears to you -- and I am summarising -- that it really very much depended on

which staff member he was in front of and how they treated him?

A. Yes.

Q. Tell us about that?

A. Yes. And Ben was like that all his life, really. If you spoke to him -- and I don't mean like you had to sort of -- just, basically, if you spoke to him with respect, you'd get that back.

Q. Yes.

A. If he knew you was deliberately trying to wind him up, torment him, bully him, then he wouldn't give that respect to you: why should he?

Q. Yes.

A. So I think it's the staff that treated him like that got that attitude back from him.

Q. Yes.

A. The staff that treated him with respect and like a human being, he spoke to them quite fine.

Q. I think you're going to go on to tell us that you do consider that there were a number of members of staff who didn't speak to him or treat him as though he was a human being?

A. Definitely, and that some of the staff have even written nasty things about him in their statements after he'd died.

Q. Yes.

A. So I actually dread to think how they did actually treat him while he was alive.

Q. Yes, so one of the statements that you've seen, a staff member describes him as something of a "wannabe gangster"?

A. "Ali G wannabe gangster", yes.

Q. To you, that is deeply offensive.

A. Yes.

Q. Tell us why. It is an obvious question, but ...

A. Just how can you write something like that? You're a professional member of staff and you're putting in your statement when someone has died, through their fault of not watching him, they add insult and write something like that about him. Another member of staff said they don't know what the family are making such a fuss about. A fuss! After your child has gone into hospital where he's meant to be safe and died 20 days later, and the family are making a fuss? And that, if it was her son, she wouldn't want him home at Christmas either. I mean, to read something like that after your child has died, that's just -- and I think it just shows what they're about: no caring, no compassion and really don't care.

Q. Your feeling, is this right, is that, if staff are

prepared to record that kind of comment in statements that are going to come to you, the family, or are going to be made public, at least within a coroner's court, one of your fears is that behaviour that isn't seen and that was going on on the ward might have reflected those attitudes far more deeply.

A. Exactly.

Q. I want to take you now, please, to the events just before Christmas but, before I do that, just tell us, when you saw Ben, let's say between 8 December when he was admitted and around about the 23rd, how did he seem to you? How was he coping? Were things improving?

A. No. He actually -- he hated it in there. He said it was hell but he said he was prepared to stay because of hopefully getting help. They let him out a lot, so I guess that helped him a bit. I'd quite often meet him in Chelmsford and I wouldn't even go to the hospital, just meet him out in Chelmsford and he could get a bit of space away from the ward and that environment. But, yeah, he wasn't very happy to be there. But he so desperately needed the help, so it was Catch-22.

Q. Yes. He was a voluntary patient?

A. Yes.

Q. So we can take from all of that that he knew that he needed help --

A. Yes.

Q. -- and that, despite the fact that he was unhappy or described it as "hell" --

A. Yes.

Q. -- he felt in himself that he needed the assistance and he ought stay?

A. Yes.

Q. One of the things you tell us is that, on 23 December, both you and Ben's girlfriend at the time spoke to him on the phone --

A. Yes.

Q. -- and that he seemed to be particularly distressed.

A. Yes. Absolutely begging, "Please, just to come and get me. I need to get out of here, can I just come home?"

Q. Yes. You reassured him that he was in the best place, and that you would come to see him the next day?

A. *(The witness nodded)*

Q. And you did --

A. *(The witness nodded)*

Q. -- you went in on Christmas Eve --

A. *(The witness nodded)*

Q. -- and you saw that he had a number of injuries to his forehead?

A. Yes.

Q. You asked him about it, obviously?

A. Yes.
Q. This was the first you knew of any incident or injuries --
A. Yes.
Q. -- and he simply said to you that his head had gone through a glass door?
A. Yes.
Q. He wouldn't tell you much more about that?
A. No.
Q. I think, is this right: you actually, on the same day, saw on the ward, at a door adjoining a communal area, a boarded-up glass panel?
A. Yes, we was all in the, like -- it's a communal lounge, family room, Christmas Eve, and -- well, it's literally, as you go into reception, they have to buzz you in to go into actually the hospital and the wards. So there was sliding doors and then at the end of the sliding doors it's from sort of top to bottom was a glass panel.
Q. Yes.
A. That was all boarded up.
Q. I see.
A. And I done -- because it's not anywhere in Ben's notes that glass was smashed or what happened, I done a Freedom of Information or a subject access, and they agree, yes, the glass was smashed and boarded up on the

early hours of Christmas Eve.

Q. Yes. In fact, having looked through all of his clinical notes that you have, the only reference to this incident -- there's no reference to what happened?

A. *(The witness shook head)*

Q. There's no reference to his injuries?

A. *(The witness shook head)*

Q. The only thing that you have managed to find is a note -- a sort of clinical note --

A. *(The witness nodded)*

Q. -- dated on Christmas Eve --

A. Yes.

Q. -- which says that Ben reported to the doctor that he had had a blackout and bumped his forehead, and there's nothing more on that?

A. No. No.

Q. You were not informed of anything about that incident at the time?

A. No.

Q. You spoke to a member of staff, I think, about the possibility of taking Ben home for Christmas?

A. Yes.

Q. That conversation you didn't find at all reassuring?

A. No.

Q. Tell us why?

A. They didn't explain, would he come -- like, how would he come home with his medication. They said that they would try and make sure he had enough medication for a few days. That worried me, for a start, because I thought, "He can't start these and then just stop and then start them when he gets back".

Q. Yes.

A. And when I saw him, to be honest, on Christmas Eve, he'd gone so downhill.

Q. He had gone so downhill? Tell us in what way?

A. He could barely even communicate, really just so quiet, withdrawn.

Q. Yes.

A. Lost so much weight.

Q. Yes.

A. His face was so gaunt. It was like he'd been given different medication, sort of.

Q. Yes.

A. Just completely different. Couldn't really sort of engage, and that -- I mean, we had his daughter with us then, as well, and he just really, really struggled.

Q. Yes. His daughter was very small at the time?

A. Yeah, she was two and a half.

Q. Before that, you had taken his daughter to visit him on the ward --

A. Yes.
Q. -- in the period leading up to Christmas?
A. Yeah.
Q. And there are notes recorded to say he was engaging with her appropriately and all was well?
A. Yeah.
Q. But by the time you saw him on Christmas Eve, this was a very different Ben --
A. Yeah.
Q. -- than the one you knew?
A. *(The witness nodded)*
Q. Your decision was that he wouldn't come home on Christmas Day because obviously you had his siblings to think of and you were concerned about how you would keep him safe?
A. Yeah, and I was almost scared that, if I had him home, would they have him back?
Q. Yes.
A. That was a worry. You know, it's taken so long to kind of get him some professional help and now he's in there, if I take him home sort of for a few days at Christmas, will they say his bed's gone or they can't have him back in there? And then we've got to go through it all again to try to get him help again.
Q. I see. So you felt worried throughout about losing the

place?

A. Yeah, I felt worried about so many different things and, obviously, number 1, for Ben's safety, it just didn't seem right.

Q. Of course.

A. And yet cruel to say no.

Q. So, Lisa, you were in an impossible position as a mother?

A. *(The witness nodded)*

Q. All right. You went to see him on Christmas Day, I think, at about 11.30 in the morning?

A. *(The witness nodded)*

Q. And you took his -- your other two children --

A. *(The witness nodded)*

Q. -- to visit him and give him Christmas presents, and so on?

A. *(The witness nodded)*

Q. How did he seem on Christmas Day morning, as compared with how you'd seen him on Christmas Eve?

A. Worse. Worse. He only -- he come out to the car. He didn't want to us go into the hospital this time.

Q. I see, yes?

A. So he come out to the car. He was in the car five, ten minutes. Then went back in.

Q. Still very withdrawn?

A. *(The witness nodded)*
Q. Still very quiet?
A. Yeah, very.
Q. At that time, Lisa, either on Christmas Eve or on Christmas Day, did you speak to staff about the change that you were seeing in him and the deterioration that you've described?
A. Well, I spoke to the member of staff about having him home and I mentioned to him that he -- you know, he was really seeming more unwell than what he was when he went in there.
Q. Yes.
A. So I mentioned it. As for specific conversation, I don't think so.
Q. No. We're going to come to the events, then, of Christmas Day afternoon, and I know that this is very upsetting for you. I want to run through them with you, though because it's so important, Lisa?
A. *(The witness nodded)*
Q. If you feel you need to stop or take a break at any point, you're going to tell me.
A. Yeah, thank you.
Q. One of the things that you and your family had given to Ben was a DVD player?
A. Yes.

Q. It's almost impossible to remember now --

A. I know.

Q. -- but it was 2008, so it's a sort of portable player that you plug in and he could watch films on?

A. Yes.

Q. After you had gone home, as usual, you spent a lot of that day on the phone with him?

A. Yes.

Q. When you spoke to him at a certain point in the afternoon, as I understand it, you were talking with him, he was -- he had told you that he was in his room --

A. Yes.

Q. -- on his bed --

A. Yes.

Q. -- and he was watching a film on the new DVD player that you had given him?

A. Er -- no --

Q. No?

A. So I probably did talk to him then as well.

Q. Yes.

A. But I'm not sure -- yes, and then they went in and took it away.

Q. Let's look at it in your witness statement because I want to make sure I'm not confusing the timeline.

A. Yeah.

Q. If you go, please -- if you look with me at page 13 --

A. Yes.

Q. -- and then I think paragraph 47.

Actually, you're quite right Lisa. It's me that's confused matters. As you explain there, is this right: Ben told you on the phone that he had been watching a film on his new DVD player --

A. *(The witness nodded)*

Q. -- and that a member of staff had come in and taken it from him?

A. Yes.

Q. Tell us what he said to you about that?

A. Just that they had come in his room and just yanked the plug from the wall and took it away and said he couldn't have it: it wasn't electric tested.

Q. Yes. So there was no indication that that staff member certainly gave to Ben that there was a risk in having the cord; it was an electrical safety issue?

A. Yes.

Q. That's what the member of staff told Ben?

A. Yes.

Q. What did Ben say to you about the way in which that had been done?

A. Just -- he just said, "He was just horrible, Mum, he

just walked in, said 'I'm not allowed that', whipped it out of the bed". And I'm sure he said he yanked it so hard from Ben that it pulled the bed away, made his bed move.

Q. Yes.

A. And, um -- yeah.

Q. When you were speaking to him about this, what you tell us -- it's still on page 13 at paragraph 48 -- that when Ben was telling you about what had happened he was calm?

A. Yeah.

Q. But while you were talking to him, he then became very agitated?

A. Not to me, no. He was still calm. He just said that they was coming to get him.

Q. Tell us that. So he wasn't agitated?

A. No.

Q. What you've said here is that he suddenly said to you, during this call, "I can hear them charging outside, they're coming for me".

A. Yes.

Q. Now, quite apart from the fact that that is obviously terrifying for you as a mother to hear --

A. Yeah.

Q. -- you managed to, yourself, be calm enough to say to him, "Stay on the phone"?

A. Yes.
Q. Did you do that because you wanted to hear what was happening?
A. Yes.
Q. Tell us what did happen, as best you can remember.
A. From what I can remember -- so Ben said he was on his bed with his phone, he said he got up, he put the phone on the windowsill. What I heard was then just Ben begging this nurse to tell him what he'd done wrong and why were they doing this to him.
Q. Yes.
A. I think I heard a member of staff saying that they could do with a straitjacket or a restraint jacket. They said after they don't use them. But Ben actually said -- so I heard them say this. Ben actually said, "You'd have to break my f-ing arm to get me in one of them".
Q. Yes.
A. So it sounded like they was being really, really quite rough with him. And I got to the point where I could -- I just couldn't listen to any more, it got too much. What were they doing?
Q. Too distressing?
A. And Ben is continuing to beg and ask what he's done wrong and why are you doing this to me? I should imagine tears were flowing by the sound of his --

Q. You could hear him crying?

A. -- the desperation in his voice.

Q. Yes.

A. So I rung his ward either from my mobile or home number, still leaving the other line open.

Q. Yes.

A. And the next thing his phone was switched off.

THE CHAIR: So he was begging them not to do this to him. What did you think at the time was "this" that --

A. I just wasn't sure.

THE CHAIR: Because did you know at that stage he'd told you about the wire?

A. Yes. I knew that the -- they'd been in and took the DVD player away. So all I could hear was just commotion and you could hear a few different staff but I couldn't make out what they were specifically saying. And then just Ben begging, "Why are you doing this to me?"

But what was they doing? That's why I got so scared that, in the end, I just had to ring and say, "What are you actually doing to my son?"

MS TROUP: Yes.

A. Because it sounded horrendous. And I don't know what they was doing until after.

Q. Yes. As far as you were aware, at that point -- so on Christmas Day 2008 -- at the time, as far as you were

aware, had Ben ever previously been physically restrained by staff on Galleywood?

A. Well, he said he had.

Q. Yes.

A. And he also said that he was injected and he also said that he nearly passed out in the shower.

Q. Yes.

A. But, again, none of it is in his records.

Q. So that's something that he told you before Christmas Day 2008?

A. Yes, it was shortly after he'd gone in there.

Q. Yes.

A. I actually thought he was restrained 11 times but that worked out wrong but he definitely said that he was restrained. They jabbed him with something it made him feel all dizzy and he thought he was going to pass out having a shower.

Q. Yes.

A. And that definitely wasn't on the 25th. That was shortly after he'd gone in there because I can remember thinking, "God, you've only been in there a day or two".

Q. Yes.

A. But the first morning he was in there he asked for a razor to have a shave, they wouldn't give him one, so I rung the ward and said, "Look, what does he do to be

able to have a shave?" And he said they went back to his room and said, "Oh you've been crying on the phone to Mummy?"

Q. A member of staff said that to him?

A. *(The witness nodded)*

Q. I see. When you called the ward on Christmas Day, having heard the commotion that you described, I understand you left the line open on your mobile --

A. *(The witness nodded)*

Q. -- because you could still hear what was happening?

A. *(The witness nodded)*

Q. You used your landline to call the ward?

A. Yes.

Q. And one of the things you said to the staff member who answered was, "I can hear everything" --

A. Yes.

Q. -- and it was not very long after that that the mobile line was -- the mobile call was switched off?

A. Yeah. It was in a nurse's statement that they went into his room and they did find his phone on the window sill.

Q. Yes. Now, we're going to come on to it, because there was a sort of internal investigation into those events --

A. Yes.

Q. -- and it was confirmed to you that Ben had been

physically restrained, just as you suspected, having heard it on the phone?

A. *(The witness nodded)*

Q. But one of the really key things that I think you want to highlight is that, in all of the minutes prior to that event, Ben was on the phone with you --

A. Yes.

Q. -- and calm?

A. Yes.

Q. As far as you are aware and based on what he was telling you, no incident was taking place that could or should have led to an incident of physical restraint?

A. No. I mean, I was always led to believe that physical restraint was literally the last -- very, very last option because it's not very nice.

Q. Yes.

A. So I just couldn't understand why.

Q. Yes.

A. Why did they do that to him?

Q. The truth is you still don't know the answer to that question; is that fair?

A. Yes.

Q. You have seen the statements from the Trust's internal investigation into those events?

A. Yes.

Q. Is it fair for me to say that your overarching impression of the content of those statements is shock?
A. Yes.
Q. Why?
A. Because they're saying a completely different account to what happened. They said that he was out in the corridor, I think kicking the skirting boards and swearing.
Q. Yes.
A. So, in their eyes, they had no option but to restrain him. But my argument to that is: how can his phone get on the windowsill in his room if they started restraining him out in the corridor? His phone would have surely dropped on the floor or something. They wouldn't have found it on the window sill.
Q. Yes and, in any event, Lisa, put it -- stating the obvious, you heard what you heard?
A. Yes, and he was quite calm talking to me. I think he'd spoke to his girlfriend beforehand.
Q. Yes.
A. And none of -- probably my mum. None of us had heard him agitated or in such a state that he would need restraining.
Q. Thank you. One of the other things that you have learned is that the staff who were present with Ben and

physically restraining him or involved in that incident were Galleywood staff?

A. Yes.

Q. At some point, the pinpoint alarm was pressed, and two members of staff from neighbouring Finchingfield Ward came to assist?

A. Yes.

Q. What you noticed are two important things: the first is that Finchingfield staff who were present took a markedly different approach --

A. Yes.

Q. -- than Galleywood staff?

A. Yes.

Q. Tell us about that?

A. They seemed to more want to use calming, talking, try and calm the situation down.

Q. Yes.

A. I think they was a bit puzzled, as well, why the staff of Galleywood Ward were doing this.

Q. Yes.

A. And then there's -- just seemed to be really a big row and hoo-ha between the staff of the two wards --

Q. Yes.

A. -- while Ben was stuck in the middle of it all.

Q. The other matter that strikes you, looking at those

statements and those records, is that, quite apart from the marked difference in approach, Galleywood staff, who you consider, and is obvious to you from the face of the records, to have been taking a very heavy-handed approach --

A. *(The witness nodded)*

Q. -- for reasons that remain unclear to you --

A. *(The witness nodded)*

Q. -- were openly critical of the different approach of Finchingfield Ward staff?

A. Yes. They just didn't seem to want the Finchingfield staff there at all.

Q. One member of staff from Galleywood, in their statement refers -- and I think to you, this is impossible to understand -- to Finchingfield staff, who had come onto the scene and were present, using "inappropriately soothing language" with Ben?

A. Yes.

Q. So we have here two sets of staff from two separate wards, using a markedly different approach?

A. *(The witness nodded)*

Q. If we can summarise it: one is sort of escalating matters and the other is attempting to de-escalate?

A. Yes.

Q. And we also have over-criticism from Galleywood staff of

Finchingfield staff trying to take a softer, de-escalatory approach?

A. Yes.

Q. The way that you see it is that the right approach was to try to calm Ben --

A. Yes.

Q. -- and to de-escalate the situation?

A. Yes, but the main thing is, is there was no situation to start with, until Galleywood staff barged in his room.

Q. Yes.

A. So there was never any situation. I just don't understand why they done that.

Q. Yes.

A. They made a situation out of something that shouldn't have been.

Q. Yes. One of the most troubling pieces of information that has come to you is a statement from a nurse. If you want to look at it, actually, Lisa, let's look at it together. This is on page 16 of your witness statement and paragraph 60.

A. Yes.

Q. A particular nurse gives an account, I think it's dated later in January 2009, where she records as follows:

"I went on to Galleywood Ward ... and a support worker ..."

As you know, we're not currently naming staff.

A. Yes.

Q. "... was walking into the office bragging to another support worker how he gone into Ben's room alone, attempted to pull Ben away from the DVD and pulled the bed out with Ben sitting on it and yanked out the plug in the middle of the film."

A. Yes.

Q. Now, that accords with what Ben had told you?

A. Yes.

Q. This staff member says that the support worker she is speaking about was describing this in a bullying fashion --

A. Yes.

Q. -- bragging about how he had said to Ben, "Don't even think about taking me on".

A. Yes.

Q. Now, to you, this all evidence that would tend to support, first of all, what you say about the fact that this was essentially -- I think you do say this in your witness statement -- I don't want to put words into your mouth, but you consider this to have been an unprovoked assault, essentially?

A. Assault, yeah, absolutely. And we do have a -- a statement was actually given to the police from this

member of staff saying that she thought it was an assault.

Q. Yes.

A. And she wasn't even called into the inquest to give evidence.

Q. No. You still don't know why that was; is that right?

A. Don't know. She was on the witness list, but ...

Q. Yes. In general terms, Lisa, I think knowing -- having that information, is this fair: those records confirm your fears about staff treatment of Ben --

A. Yes.

Q. -- while he was there?

A. Yes.

Q. Again, I don't want to put words into your mouth but, really, if we can summarise it, one of the things that I understand you to be very keen to get across is that, rather than being in a safe place, the attitudes and approach of staff, in fact led to a very marked deterioration in Ben's mental health?

A. Yes.

Q. Is that fair?

A. Yes.

Q. What occurred in the evening because we understand that there's a policy to review a patient once there has been an incident of physical restraint?

A. Yes.
Q. You have seen the duty doctor's note from about 9.00 pm on the evening of Christmas Day --
A. Yes.
Q. -- where the following is recorded, where he says, "The policy is to review someone after restraint", so that's why that's being done, and he describes Ben as "pleasant and cooperative" --
A. *(The witness nodded)*
Q. -- and that Ben says he couldn't remember the details or events leading to the restraint and hence couldn't discuss it?
A. Yes.
Q. Lisa, what are your views about why, by the evening, Ben might have been presenting as pleasant and co-operative and saying he couldn't remember the events?
A. Well, I think -- I don't think it's by the evening. I think he was quite pleasant all day, until sort of they barged in and done that to him. He was fine before that.
Q. Yes.
A. Like I say, it wasn't like anything massive sort of happened to warrant them going into his room and restraining him.
Q. Yes.

A. And I don't think he mentioned too much because I think he'd then got the understanding that, if you kind of complain, you get treated worse, really. After the shaving incident and them then tormenting him that he'd been ringing me and that he'd been "crying down the phone to Mummy". You don't really want other patients and people to hear staff treating you sort of that way.

Q. Yes, and you might also take steps to protect yourself from that kind of treatment?

A. Yes. So I think he was dubious then to speak up and -- so when this doctor went in and he was pleasant but couldn't really remember anything, I think that was his way of just, look, this happened, let's just not cause any more trouble, and didn't really say much.

Q. Yes. Lisa, do you consider that he was afraid?

A. Do you know what, that's a really funny question because Ben had no fear in life at all but I think it was the first time ...

(The witness nodded)

Q. That he did feel fear?

A. That I'd actually seen him frightened and I think worried for his own safety, possibly even life.

Q. Yes.

A. It's just so odd that the 23rd he was begging to come out of there and his head goes through a window, then

Christmas Day this restraint happens to him. So he must have been aware that they didn't like him.

THE CHAIR: Forgive me for asking you this: Ben, you describe how he could be aggressive sometimes.

A. Aggressive more verbally than physically.

THE CHAIR: Okay, and was he a big person? Was he ...?

A. No, he was about 5-foot 5. But he was very muscly, and he was really, really strong. Almost unhumanly strong.

THE CHAIR: Did you ever see him be physically aggressive?

A. I've seen him, like I said, not aggressive as such, but bashing his head.

THE CHAIR: But not to other people?

A. No, never seen him physically aggressive to anyone.

THE CHAIR: Thank you.

MS TROUP: I think, in terms of his size, I think he weighed about 70 kilos in 2008, didn't he?

A. *(The witness nodded)*

Q. He was slender?

A. *(The witness nodded)*

Q. He might have been muscly but he had about a 28-inch waist?

A. Yes, his waist went from that to that *(indicates)*, sort of thing.

Q. Yes, I understand. Lisa, I want to move on to talk a little with you about periods of leave that Ben was

granted and then, once we've done that, depending on how you feel we're going, I'm going to suggest that we take a short break?

A. All right.

Q. Talking about leave, you've told us earlier that he was allowed to leave the ward. On a number of occasions, you met him in Chelmsford, and so on?

A. Yes.

Q. Of course, we bear in mind that he was a voluntary patient?

A. Yes.

Q. So he wasn't detained?

A. No.

Q. But there are a couple of things we want to note, I think, about the way in which leave was handled for Ben. These are matters that do come up, both in the SI report and the PHSO reports later.

A. Yeah.

Q. One of the matters that you raise -- I don't think it's in your witness statement, actually, but that you raised to the PHSO was that it appeard to be -- his leave appeared to be mismanaged and disorganised in such a way that on one occasion you arrived at the ward to see him and staff didn't know where he was?

A. They didn't even know that he wasn't there. I'd met Ben

in Chelmsford town, we'd got him a dressing gown, some slippers and some bits, and he said, "Mum would you mind just running my things back to the hospital, just dropping them off and I might hang around in town for a bit more".

Fine, so I got to the hospital and I said, "I've just brought some things in for Ben", and they said, "Oh, we'll go and find him, go and get him for you". Well, of course he wasn't there, he was in the town, and must have been gone for a good half an hour until they come back and told me they couldn't find him, and I said, "Had you not rushed off so quick I would have actually told you that I'd just met him in the town". They didn't even have a clue that he'd even gone out.

Q. No. One of the things that the PHSO noted in their report, it's quite a significant finding, is that there was a service failure in relation to the management of Ben's leave. What we know is that what you've discovered is that there were at least three occasions on which he was granted leave, including overnight leave --

A. *(The witness nodded)*

Q. -- and, on none of those occasions, does there appear to have been any risk assessment carried out?

A. No.

Q. There appears, on none of those occasions to be any documented rationale for granting leave?

A. Mm-hm.

Q. Nobody appears to have recorded contact information or details of where he was planning to go --

A. No.

Q. -- or who he was planning to be with?

A. No.

Q. On one occasion, he was granted leave on the very same day that his medication had been increased?

A. Yes.

Q. On another occasion, he was granted leave the day after an incident of physical restraint?

A. Yes.

Q. In fact, I think that's Boxing Day --

A. Yes.

Q. -- 26 December?

A. Yeah.

Q. What the PHSO found is that, essentially, to summarise, the Trust had not managed Ben's leave even vaguely in line with its own policies and guidlines?

A. Yes.

MS TROUP: We're going to come on, I think -- we've been running now for around about an hour and 15 minutes, and Chair, as long as you're content, I wonder whether we

could take a short break of ten minutes now?

THE CHAIR: Yes.

(11.33 am)

(A short break)

(12.01 pm)

THE CHAIR: Ms Troup.

MS TROUP: Chair, thank you.

Lisa, before we move on in time, we were talking about the events of Christmas Day 2008: what you remember about it and what you've learnt about it since.

A. *(The witness nodded)*

Q. I just want to just take you to another piece of information that you've set out for us about that. If you look, please, at page 50 of your witness statement and at paragraph 129, which is the bottom paragraph on that page. Is this right: you have learned, I think, through statements made for the coroner at inquest that police attended Galleywood Ward on 25 December to speak to Ben?

A. Yes.

Q. Now, is this right: you didn't know that at the time --

A. No.

Q. -- and neither staff nor Ben himself told you about that in the days between Christmas Day and the 28th when Ben died?

A. Yes.

Q. What is really key for you, I think, to highlight is that one of the officers who attended on Christmas Day to speak to Ben was an officer who knew him already?

A. Yeah.

Q. What that officer says in his or her statement is that when they attended, they found Ben crying on his bed?

A. Yes.

Q. That he was extremely subdued --

A. Yes.

Q. -- and upset?

A. Yes.

Q. And that he asked officers, "Have I hurt anyone?"

A. Yes.

Q. Now, that is something you referred to a little earlier in your evidence, that he would have these periods where he appeared later to be -- or even shortly afterwards -- unaware of what had taken place?

A. Yes.

Q. This officer goes on in the statement to say:

"Ben is someone I know and have spoken to in the past."

A. Yes.

Q. And describes him as a "cheeky chappy"?

A. Yes.

Q. Someone who is very forward?

A. Yes.

Q. Almost a little bit jumpy?

A. Yes.

Q. And does so, I think, because that officer wants to note, and does so in terms in this statement that was produced for the coroner, that the officer found him to be a completely different person when she attended the Linden Centre on Christmas Day 2008?

A. Yes.

Q. Now, confirming what you've told us about how you saw him on the 23rd, 24th and 25th, at the very bottom of the section of that officer's statement you have set out -- this is on page 51 -- the officer says this:

"However, during the incident on Christmas Day, I felt that he had almost crawled inside himself and was very quiet and, as I previously said, he spoke in almost a whisper ..."

A. Yes.

Q. Does that concur with your memory of how Ben was at that time?

A. Yes, yes. Not at all the Ben we knew.

Q. Thank you. We know that, following that incident of physical restraint on Christmas Day 2008, Ben was granted leave --

A. Yes.
Q. -- and he went to be with a friend?
A. Yes.
Q. Did you know that at the time?
A. No.
Q. No. We've discussed the mismanagement of Ben's leave and the fact that it does not appear from the records or any of the interviews carried out by the SI panel that any proper risk assessment was carried out. What you also know, having looked at the statement of a police officer produced for the coroner, and I think from having looked at some of the messages on Ben's phone --
A. Yes.
Q. -- is that, while he was on leave on 26 and/or 27 December, he obtained a knife and took it back with him onto the ward?
A. Yes.
Q. Do you know why he did that?
A. I have his -- the friend he stayed with, I have what he has said but that is all. I don't have evidence as such.
Q. No, what did the friend say?
A. That he thought his life was at risk, so he took a knife in there to protect himself.
Q. Yes. One of the things you ask in your witness

statement, it's a little later on, is that you have asked yourself many times, since discovering those facts, why it was that your son, having been placed as a patient in a facility that was meant to care for him, felt the need to arm himself --

A. Yes.

Q. -- for protection?

A. Yes. And how did he get in with the knife? Why wasn't he searched?

Q. Yes.

A. And questions go on and on: why didn't the police investigate the knife?

Q. Yes. What you tell us is that you have seen, from records, that a detective inspector at Essex Police in a statement submitted to the coroner confirmed that a knife was recovered in the Linden Centre --

A. Yes.

Q. -- and that handover notes from that day have a question mark next to the recording of a knife having been recovered?

A. Yes, apparently the knife was put in a see-through bag and it said, "Ben?" on the bag.

Q. On 28 December, you spoke to Ben a number of times by phone?

A. Yes.

Q. Is this right: throughout that day he continued to be very subdued and very quiet?

A. Yes, but also still, having said that, very calm. He didn't seem agitated. I mean, we had a phone conversation reading out the lottery numbers and he was engaging more but still so flat. But, like I say, calm, and we've all said that: his girlfriend, my mum. We all spoke to him that day several times, and not at any time did he seem agitated, which then confuses me that apparently he kept asking for more medication because he was agitated.

Q. Yes. So what you've seen in the records -- Trust's records is that staff have recorded that he was agitated throughout that day?

A. Yes.

Q. Staff have recorded that he was requesting more medication?

A. Yes.

Q. You know that he was, apart from the atomoxetine that had been prescribed and increased -- I think doubled by then --

A. Yes.

Q. -- he was essentially being prescribed lorazepam on request --

A. Yes.

Q. -- as well as zopiclone to help him sleep at night?
A. Yes.
Q. When you last spoke to Ben, as I understand it, it was at around about 8.25 pm --
A. Yes.
Q. -- on the 28th?
A. Yes.
Q. What you tell us in your witness statement is that you knew immediately that something was not right?
A. Yes.
Q. Tell us how you knew that?
A. He was just slurring. Like I've never ever heard him speak like that in all his life, ever. I could barely really make out what he was saying. I've never heard anyone speak like that before, slurring like that before, ever.
Q. What you did manage to make out from what he was saying to you is that he was agitated?
A. Yes, he was then, yes.
Q. Desperate to get out of the Linden Centre --
A. Yes.
Q. -- and expressing to you that he was going to kill himself?
A. Or someone else, yes.
Q. Or someone else?

A. Yes.
Q. You obviously were -- I think the way you've put it is that you were beside yourself with worry?
A. Yes.
Q. And your response quite naturally was to immediately contact the ward?
A. Yes.
Q. You told the member of staff that you spoke to what your concerns were --
A. Yes.
Q. -- and what Ben had just said to you?
A. Yes.
Q. So this would have been at some point between 8.30 and 9.00 pm?
A. Yes.
Q. What was the response from that member of staff you spoke to?
A. Well, they said, "Well, that's fine", they'd heard him. So I presume he was near, perhaps, their office or I think he called me from his mobile but he may have called me from the pay phone, which again I think was near the office. They'd heard him, what he -- and they'd heard what he said about he was going to hurt someone or himself.
Q. Yes.

A. And that they was waiting for the duty doctor to come to look into discharging him and sort his medication out. Should be around about 9.00 and, obviously, they'd keep a close eye on him until then.

Q. Yes. Did you feel at the time that your concerns were being taken seriously?

A. At the time I think I did, yeah. I honestly still felt that he was in the safest place, staff know what they were doing, nothing could happen to him because he's there with all them people watching him.

Q. Yes. So you were made aware that he had been asking to be discharged --

A. Yes.

Q. -- and that the duty doctor had been called --

A. Yes.

Q. -- to come and see Ben and to review the situation?

A. Yes, and that it really shouldn't be too long before the duty doctor got to the ward.

Q. Yes. Now, just going back a little -- I'm sorry, I should have covered this -- is this right: I think when you spoke to Ben in that last call at 8.25, he told you that there had been some discussion with a member of staff about housing?

A. Yes.

Q. Tell us about that?

A. He told me that the staff were deliberately winding him up saying that he was only there because he had nowhere to live. Obviously, they had his address, he had a flat with his girlfriend and his baby daughter in Harlow, and he most definitely had somewhere to live. And that staff were telling him that he was probably just -- he had a criminal thinking way of mind and that he is the way he is because it's his mum's fault, how I've brought him up.

Q. Ben told you that staff had said that to him?

A. *(The witness nodded)*

Q. He had said to staff, I think, that he was going to hurt himself or someone else?

A. Yes.

Q. Did Ben also tell you that staff had said, "Well, that's a decision for you and, if you do such a thing, we'll call police"?

A. Yes, they -- he said that they warned to call the police on him again.

Q. Yes.

A. I've actually lost count of how many times they called the police and at Christmas, like when the police come, I don't think they really knew why they'd been called because, like they said, Ben was calm --

Q. Lying on his bed crying, yes.

A. Yes.

Q. When you spoke to the ward, Ben, having told you all that -- and you told us that you've never heard him like that before --

A. *(The witness nodded)*

Q. -- he was so slurred and very agitated.

A. *(The witness nodded)*

Q. I think when you rang the ward to tell them about your concerns, you also told them about what Ben had just told you: that they were winding him up and telling him that he was only there because he was homeless?

A. Yes.

Q. What was the member of staff's response to that?

A. That was, "No, not at all". It wasn't at all like Ben's version, "He must be confused, he must be this, he must be that", they didn't say it.

Q. Yes. Did you speak to that staff member about what Ben had said to you, that staff were saying to him, "Well that's just criminal thinking"?

A. Yes.

Q. What was --

A. They denied saying any of that to him.

Q. Yes. Lisa, what we now know from the records and of course there would be no way for you to know this at the time, is that the two staff members who had been dealing

with Ben on that evening and who had called the duty doctor to come and review him, actually left work half an hour before their shift was due to finish at 9.00 pm?

A. Yes.

Q. Your understanding, and this is from the Serious Incident Report, is that that is a practice that is permitted --

A. Yes.

Q. -- as long as the ward is quiet and safe?

A. Yes, and according to them, and obviously then me, what I heard, it wasn't. It wasn't quiet, and safe.

Q. Right.

A. Ben was on the phone to me really, really agitated. So how can they just think, "Oh, we're off now", half an hour early?

Q. Yes, and they themselves had reported that agitation and that they had warned him about possibly calling police?

A. *(The witness nodded)*

Q. So, in your view, is this right, the ward was anything but quiet or safe?

A. Yes.

Q. I want to take you, please, to the following morning and to what you had to go through --

A. Yes.

Q. -- in order to learn that your son had died?

A. Yes.

Q. My understanding is that you phoned the ward as normal to --

A. Yes -- well, I tried to phone Ben, first, but obviously ...

Q. There was no answer. I'm going to take you through this, Lisa. You tell me if I have anything wrong.

A. Yeah.

Q. You called the ward and were told to call police?

A. Yes.

Q. You were not told why you were to call the police?

A. No.

Q. You followed that instruction and called police --

A. Yes.

Q. -- who told you to call the ward?

A. Yes.

Q. You went round in circles in that way --

A. Yes.

Q. -- three times?

A. Yes.

Q. On one of those calls to the ward, you heard a member of staff saying, "This is not fair".

A. Yes.

Q. In your last call to the police, presumably by then substantially panicked --

A. Yes.

Q. -- an officer asked you for your address --

A. Yes.

Q. -- and about 15 minutes later, two officers attended?

A. Yes.

Q. You describe the way in which those officers came to break the news to you that Ben had died as "brutal beyond belief"?

A. Yes.

Q. I understand that they were in your home for less than ten minutes?

A. Oh, I mean, I think they was at my home for less than ten minutes. Actually inside: two minutes?

Q. Is this right, Lisa: when those officers left your home, you were on the floor having collapsed?

A. Pretty much, yeah, my partner was picking me up off the floor. My legs just -- well, they just went. It felt like I had no legs.

Q. Yes. Was there any compassion or care from those officers?

A. No, it seemed, actually, quite the opposite, quite hostile and just really not very nice. They didn't give me any information, they didn't tell me who to call, they didn't tell me what the future process was: nothing. Just pretty much left me on the floor.

I mean, you see it on the telly and they say, "Oh, there's a police liaison officer", is it, to help you?

Q. Yes.

A. And, "Would you like a cup of tea, nice sweet cup of tea?" Nothing like that at all in real life, not in my experience.

Q. Lisa, what did those officers tell you about how Ben had died?

A. Well, I opened the door and, I mean, before they'd even come, I said to my partner, "Ben's dead", and he said, "Don't be so silly, he's in hospital, he's in the safest place he could be".

When them policemen knocked on the door, I think as soon as I answered the door, I said, "Is Ben dead?" And they said, "Oh have you already heard? Can we come in?"

So they come in told me that, yeah, he'd been found dead in his room the night before and I think that's really all they said.

Q. Yes.

A. So, at that stage, I don't think I even knew how, or why, or what had actually happened, until I think I rung Chelmsford police and then they put me in touch with the policeman that was dealing with it.

Q. Yes.

A. And then he gave me an account of what happened, which

is actually completely different to the account of what's in here.

Q. Now, we know -- and you and I talked about this at the very start of your evidence -- that you have a very large number of outstanding questions about what has been said by staff, by police and in the records, about the way in which Ben died?

A. Yes.

Q. Those matters were the large part of the subject of your later letter to the Chief Constable of Essex Police?

A. Yes.

Q. For now, one of the things I want to concentrate on is on the subject of you being told about what had happened. Have you ever, sitting here today, been given any explanation as to why it was that you were not contacted until the following morning?

A. I think it was that they didn't have my address. I think that's the only explanation I was given.

Q. Can that be right?

A. Possibly. We had just recently moved but I did log my new address with the hospital.

Q. I see. And the hospital had your number?

A. Yes.

Q. One of the other things that you say -- if you want to look at it, Lisa, this is at page 45 of your witness

statement, and at paragraph 10. So page 45 and it's the second paragraph down --

A. Yes.

Q. This actually comes from your letter to the Chief Constable but is very relevant to the matters we've been discussing. Now, you have learned that Ben was discovered at 9.00 pm --

A. Yes.

Q. -- and that attempts were made to resuscitate him?

A. Yes.

Q. That he was declared dead at 9.43 pm?

A. Yes.

Q. One of your central questions is that, given that you were speaking to staff between 8.30 and 9.00 pm, given that you were reassured that the duty doctor had been called --

A. Yes.

Q. -- that he was awaiting review --

A. *(The witness nodded)*

Q. -- and that there was clearly awareness on the ward that he was agitated and needed to be seen by a doctor --

A. Yeah.

Q. -- you cannot understand how Ben would have managed to take his own life in that very short period?

A. Yes.

Q. Is that fair?
A. Yeah. Why was he not being watched, like they said?
Q. Yes. One of the things you say, going back, please, if you want to look at it with me, to page 23 of your statement and to paragraph 78 -- Lisa, you say there that you do understand that there were aspects of Ben's behaviour that might have been challenging during his period --
A. Yes.
Q. -- on Galleywood?
A. Yeah.
Q. But your understanding, from what you saw at the time and from what you've seen in records since, is your view is that his condition was made worse by the treatment he received; is that right?
A. Yes.
Q. He was, in the end, a mental health patient --
A. Yes.
Q. -- and he was there because he himself wanted to be well --
A. Yes.
Q. -- and wanted assistance?
A. Yes.
Q. One of the statements you have seen, which I think was submitted -- it's actually the notes of an interview for

the Serious Incident Report with a member of staff from Finchingfield Ward -- you set it out. It starts at the bottom of page 23. You tell us, you set out quite a bit of that statement there because it's hyper-relevant to what you describe as an appalling lack of care. I want to take you through that. This staff member told the Serious Incident Panel the following things about Ben and about his treatment on Galleywood:

"Nobody listened to what he was saying ..."

This is at the top of page 24.

A. Yes.

Q. "... or to the subtext: I have a life, I need help. They just sent him to his room or threatened to call the police. They only saw the aggression. The doctors increased his medication and then sent him on leave. On Finchingfield Ward, we'd have sat him down and spoken to him if he got angry. We have very few aggressive incidents on Finchingfield. There is a different feeling, there isn't the fear factor."

Now, Lisa, that ties in with everything that you have been telling us about your impression of Galleywood Ward and how Ben felt on it, does it not?

A. Yes.

Q. The "fear factor" this member of staff appears to describe, includes a fear of getting involved with

"difficult patients" --

A. *(The witness nodded)*

Q. -- or so-called "difficult patients"?

A. *(The witness nodded)*

Q. This member of staff attributes that to a different management style between the two wards?

A. Yes.

Q. When is the first time you saw this account?

A. Of?

Q. That this member of staff gave? Did you see that in preparation for this Inquiry?

A. No.

Q. You saw it at some point after seeing the SI report?

A. Yes, yes.

Q. I think -- you must tell me if I'm wrong -- one of the most striking matters to you in this interview of that member of staff is that this person says as follows:

"The saddest thing is that a different staff group and a different culture might have resulted in a different outcome ..."

A. Yes.

Q. And that is the life of your son?

A. Yes.

Q. As far as you are aware, there was at no time any kind of structured or settled care plan for your son?

A. No, he didn't have a care plan. They done the initial, is it the three-day, or -- and then after that I think -- I don't think they knew what to do with him. He didn't -- there was no plan for him.

Q. There was no therapy, talking therapy or therapeutic care of any kind?

A. No.

Q. Is this right, from what you've told us: Ben felt that, he felt that there wasn't a plan, there wasn't a structure, there wasn't any kind of monitoring of his state or whether or not he was improving?

A. Yes. I think they just sort of stuck him on medication and kind of, "Get on with it".

Q. Yes. If we look, please, at page 26 of your witness statement, this is where you summarise for us some of the findings of the Serious Incident Report and I think it's right for me to say, and I think you would agree, that the findings in that report were of significant failings --

A. Yes.

Q. -- and were very wide ranging?

A. Yes.

Q. The section of the report that you quote there says this, again, bearing out, Lisa, exactly what you felt at the time and have described:

"Nursing staff on Galleywood Ward as a team did not offer Mr Morris the care he needed, instead regarding him and overtly treating him as a threat and nuisance. They did not consistently act professionally or with competence ..."

Failed to assess or plan for risks. Failed to monitor his condition. Failed to evaluate his progress. Failures to monitor all the potential side effects of his treatment -- that means the medication --

A. Yes.

Q. -- as we discussed --

A. Yes.

Q. Started treatment based on a tentative diagnosis that had not been corroborated by a specialist.

A. Yeah.

Q. Did not take steps to communicate treatment plans effectively to the nursing staff, who were actually caring for him day-to-day.

A. Yeah.

Q. Failed to follow the principles of the Care Programme Approach --

A. *(The witness nodded)*

Q. -- or the Trust's own policies.

A. Yeah.

Q. Failed to assess the risks posed by fixed ligature

points in the room.

A. Yes.

Q. And the report describes the management and leadership of Galleywood as a whole as of a "low standard"?

A. Yes.

Q. In conclusion, significantly, the report says this:

"... the Trust failed Ben Morris, did not discharge its obligations to him and must learn from this."

A. Yes.

Q. You then go on to set out the 17 recommendations that were made and they are, as we've said, very wide-ranging. They cover all the matters that you and I have discussed and more.

A. Yeah.

Q. Lisa, I don't intend to list them because we have them and there they are, and they're well summarised in the paragraph that we've just read, but I think the key is this: as far as you are aware or have been told, have any of those recommendations been implemented?

A. No, no. And I think the proof is in the pudding there. People are continuing to die, losing their lives and in very similar situations. So I can't see that any of these recommendations have been followed.

Q. One of those, of course, is Mrs Leahy's son Matthew, who died in the same place --

A. Yes.
Q. -- in November 2012?
A. Yeah, I think he was in the bedroom next door or the bedroom opposite Ben.
Q. Thank you. I understand that it's been a matter of significant further pain to you that those deaths have continued --
A. Yes.
Q. -- despite that very wide-ranging report and the failings that were found?
A. Yes. It doesn't seem to matter what recommendations are made: it's whether the staff are going to follow them or not.
Q. Yes.
A. And it seems that, if they don't, there is no punishment, no -- it's almost like they can --
Q. Accountability?
A. -- do what they want and they're not in fear of getting the sack or anything happening to them. They can just run it how they want to run it, sort of thing, and when deaths happen -- again, I done a Freedom of Information asking how many deaths there'd been.
Q. Yes.
A. Ben's own death was not even in that. They said none.
Q. Yes. So --

A. So how do they hide these deaths?

Q. When did you make that Freedom of Information Request, just roughly?

A. Again, it was me and Melanie. We done a lot of Freedom of Information.

Q. Yes.

A. I think around 2015, we done them.

Q. I see, yes.

I want to talk a little to you about the inquest that took place in February 2011 and your experience of that, Lisa.

A. Yes.

Q. It was a jury inquest under Article 2?

A. *(The witness nodded)*

Q. But I think, overall, to you, the process felt rushed; is that right?

A. Yes. Perhaps I was expecting too much from the inquest but I really thought that, "Oh, I'll get all the answers", and the staff would have to tell the truth. I mean, the staff didn't even know what their statements said. And you'd have thought that, if they'd have dealt with a death, that would be in there. One member of staff said she couldn't even remember if she rung the ambulance or somebody else did.

Q. Yes.

A. And I can't get my head round that. If someone's died, they're on the floor, you go and ring an ambulance, you would remember that. It's like they didn't want to say wrong -- really, the wrong thing.

Q. So they were being careful in what they said, was your impression?

A. I think so, yeah. And it didn't seem to worry anyone that, "It was too long ago, I can't remember now", wishy-washy answers. That was -- all seemed fine, not unusual to the inquest team.

Q. Yes, I see. As a whole, you were deeply unsatisfied with the inquest process?

A. Very much so. I think I come out with more questions than what I went in there with, really.

Q. Yes. That's one of the reasons, as I understand it, that you became involved in the campaign for a statutory inquiry?

A. Yes.

Q. It's one of the reasons that you went on to write the detailed letter that you did to the Chief Constable at Essex Police?

A. Yes.

Q. It's one of the reasons that you're sitting here today?

A. Yeah. As well -- can I just say, as well --

Q. Please do.

A. -- the inquest was set for a lot longer -- or for longer than what it actually -- than what happened. It finished on a day and I was told that the coroner had heard enough evidence, she didn't need to hear any more, and that was it. So it didn't even go full term. And I didn't know, at the time, but one of the members of staff who thinks Ben was -- it was assault, instead of restraint, was --

Q. On 25 December?

A. Yes, she was turned away from the inquest. So how can the coroner say she'd heard all she needed to hear but she hadn't heard everybody's -- who was on the witness list. That just seemed really odd to me.

Q. Yes. Lisa, were you legally represented during the inquest proceedings?

A. Yes.

Q. The jury concluded, you record at the bottom paragraph of page 31 of your witness statement, that Ben killed himself whilst the balance of his mind was disturbed, before his illness was fully diagnosed to enable a suitable care programme to be implemented to manage this condition. These factors more than minimally contributed to his death.

Now, to you, that is not a comprehensive finding; is that a fair way for me to put it?

A. Yeah, definitely. Because again, I feel that half of the actual evidence didn't even go into the inquest. It was never questioned why Ben's injuries aren't on his postmortem or -- none of that was relevant in it. It was just: question the staff; they can say, "I don't remember"; let's all go home.

Q. Yes. Now, if we can, I'd like to move on to the more recent PHSO report, that was published in 2019. The title of the report was "Missed Opportunities, what lessons can be learned from failings at the North Essex Partnership NHS Foundation Trust?" That report dealt with both your son's death and the death, four years later, of Matthew Leahy.

A. Yes.

Q. I think we can summarise to say that it was highly critical of the care that both young men received?

A. Yes.

Q. A series of failings, significant failings, were found in both cases?

A. Yeah.

Q. Perhaps most importantly of all, that report concludes by saying, "We believe that" -- this is the PHSO report from 2019:

"We believe that in an organisation committed to learning and improvement, the evidence from these cases

should have prompted immediate action, led from the very top of the Trust with senior accountability for delivering and evidencing improvement. Instead, it appears that there was a systemic failure to tackle repeated and critical failings over an unacceptable period of time."

A. Yes.

Q. Lisa, you and I sit here now in 2026. What is your view about any changes or improvements, if any, since those words were published?

A. I don't think there's been any improvement. From what I keep reading, it's getting worse. Every time I sort of go online, there's another death, especially on the trains. It's almost every day you read about someone that has took their life on a train.

Q. Yes. We're going to come in just a few minutes to the matters that you have set out in your witness statement that you would like to see changed --

A. Mm-hm.

Q. -- and your own recommendations for change that you would like both the Chair and the wider public to hear.

A. Yeah.

Q. But I want to talk very briefly a little, and not in too much detail, about the impact on you, not only of losing your son but of all that has taken place since then.

A. Mm-hm.

Q. If you look, please, just at page 35 of your witness statement, Lisa --

A. Yes.

Q. -- and at paragraph 107 there. What you tell us is that it's not possible for you to convey the devastation that this has wrought in your life and that knowing that he suffered as he did has made it a million times worse.

A. Yes, because we haven't mentioned it yet but I strongly believe that Ben was strangled by someone else --

Q. I see.

A. -- and then it was all passed through as a suicide.

Q. Yes.

A. His injuries, even his own tattoos, aren't on the postmortem report. I actually looked at the postmortem report last night and there's a little box on there that says, "Body surface, a musculoskeletal system", and then it asks you to list, including injuries, "marks of identification, e.g. tattoo marks or old scars". Well, that box does not say what tattoos Ben had.

Q. Yes.

A. So even his own tattoos aren't on the postmortem --

Q. They're not recorded. I understand.

A. -- and nor are the injuries. So how can I believe that even -- have they got the wrong person?

Q. Lisa, your fears around what has been recorded and what is said to have happened, in terms of Ben's death, are those matters that you set out in a very detailed and comprehensive way in your letter to the Chief Constable.
A. Yes.
Q. There you have recorded all your concerns, including the ones you've just raised about the way in which injuries were recorded or not recorded --
A. Yeah.
Q. -- the discrepancies that you see between the photographs --
A. Yes, what the police took themselves --
Q. -- and what is described --
A. -- of Ben. After he passed away, he was still laying on the floor in his room when the police took the photos of him.
Q. Yes.
A. And, again, what you can see in the photos, is not logged on the postmortem report.
Q. Is different, yes, I understand?
A. There's like -- and it's not just little things. Ben had a -- he used to wear a thick gold chain. You'll actually see it when the photos come up.
Q. Yes, it's in one of the photographs?
A. Yes, well, that has sunk in his neck here, several links

of it. I didn't see that, obviously, until I saw him at the chapel of rest because I wasn't told that I could go and see him.

Q. Now, let's come to that. So one of the things that you have flagged -- well, two things, in fact, and then we'll go on -- but one of the things you tell us is that nobody informed you that you could go and see him; is that right?

A. Yes.

Q. The other thing you flag is that the pathologist who carried out the postmortem has, since that time, been struck off?

A. Yes.

Q. That too is a matter that raises obvious questions for you about the adequacy or quality of the postmortem?

A. Yes, because one of the things he was struck off for was filling in someone's death certificate with the wrong cause of death.

Q. Yes.

A. And also, what concerns me is he's actually -- he's down as a histopathologist.

Q. Yes.

A. I've tried to find out if he's actually even qualified to perform a postmortem.

Q. I see.

A. And also another one of my questions was, or is still, should he do it alone as well? Should there not have been someone else with him?

Q. Yes. Now, all of these -- I'm sorry, I don't mean to interrupt you but I want to reassure you, if I can, that all of these concerns that you've set out so comprehensively in your letter to the Chief Constable, they're in your witness statement, and they therefore stand as your evidence to this Inquiry?

A. Right.

Q. They have already been and will continue to be considered by the Chair and the Inquiry team.

A. Yeah.

Q. One of the things I wanted to ask you about was that -- well, you must tell me. Do you think it is fair for me to say that, because of your remaining and outstanding concerns, you have been quite vocal with your questions about not only the care and treatment, or lack thereof, that was provided to Ben but about the circumstances of his death?

A. Yes.

Q. And, in your view -- and I don't take it any further than this and we needn't go into detail, Lisa -- but in your view, efforts were made by the Trust to silence and to discredit you as a result?

A. Yes. It seemed the more and more I was finding out the truth, like the wardrobe handle was just glued on, so not -- again, not only -- could it have held Ben's weight? But literally for, like your chain to embed in your skin, would it have really held that much weight for that pressure, to -- you know, so many, so many, so many questions unanswered, and I don't know where else to go to try to find the answers out.

Q. I understand.

A. It's not the sort of thing where you can just ring someone and say, "Hey, you know," even, is a histopathologist qualified to do a postmortem? There's just no -- you try and Google it and you get nowhere.

Q. For you, Lisa, there are so many of these questions that remain --

A. *(The witness nodded)*

Q. -- and you've explained to us that the inquest process for you really led to more questions than it answered.

A. Yeah.

Q. These are the questions that, as a grieving mother, continue to torment you?

A. They do, yeah. Yeah, absolutely. I mean, the belt they say he used: I know that's not his belt. He never would have wore a belt that long. It was far too long for his

waist. I never got his belt actually back. He had one very similar. One nurse said that when they tried to cut Ben down it actually broke the ligature scissors but the belt actually looks like it's been cut through a guillotine. It's one clean cut. There's no fraying, there's no sign of where it's been supposedly tied or looped, just --

Q. Would it be fair for me to summarise it in this way: The questions that you have about the events of Ben's death are almost endless?

A. Yes, they actually are, yes.

THE CHAIR: You have set out very many of them in your statement. I have seen them.

A. Yeah, yeah.

MS TROUP: In general terms, Lisa, is it right for me to say that you consider not only that Ben was failed by those were charged with caring for him --

A. *(The witness nodded)*

Q. -- but also that he was doubly failed by those who, in your view, might and should have investigated?

A. Yes, definitely. And I have tried. I've tried so hard to read all this and see what the -- you know, see what they're saying and come to terms with, okay, no, he took his life off of a wardrobe handle. I just can't, because --

Q. To you it --

A. -- it's just --

Q. It continues not to make sense?

A. Yes.

Q. Yes, and your mind cannot rest?

A. Yes.

Q. I understand. Lisa, thank you.

You have set out at page 53 of your witness statement some handwritten notes that Ben himself wrote and I wondered whether you wanted me to read those. You've recorded them for a reason.

A. Yeah. I think, really, I'd probably prefer not because these are Ben's very personal thoughts and feelings that he wrote for his psychiatrist to try to understand what was going on --

Q. Yes.

A. -- in his head and, in that way, I think Ben was quite private, I don't think he would like everybody to hear that, if that's okay?

Q. I fully understand. Of course it's okay. They're deeply private matters and the reason, really, that I take you to them at all is that what they do tell you is that when Ben's psychiatrist asked him to try to record what was happening inside his own head, he did and so he tried so hard --

A. Yes.
Q. -- echoing what we said a little while ago --
A. Yes.
Q. -- which is that you know that what Ben wanted was to be well?
A. Yes. And this list that Ben wrote for his psychiatrist, I was tormented, at least two times, that that was a suicide note. That he'd left a suicide note? Then no, it turned out to be that list. Then again I was told there's a suicide note. Again, it turned out to be that list.
Q. I see. It was this list. So that we're clear, we're not hiding anything, it was a list of how he was feeling --
A. Yes.
Q. -- and what he was experiencing?
A. Yes.
Q. Lisa, thank you. I'd like to move on, as long as you are ready, to page 55 of your witness statement and to the matters you've set out in terms of recommendations and changes that you would like to see.

There are 12 that go across a number of pages and, as long as you're content, we'll take those in turn.
A. Yeah.
Q. So the first is that you consider that, at the outset of

mental health inpatient care, there should be a comprehensive assessment of each patient, including a physical and mental health assessment?

A. Yes.

Q. Tell us why you think that is so important?

A. I think the physical side, like I've put in here, just a routine blood test to check your vitamins: your level -- B12, your vitamin D. I think that can really play a part in mental health that, if you're low in them, you're feeling pretty bleurgh.

Q. Yes, and what you're recommending is what you've described as a genuinely holistic approach --

A. Yes.

Q. -- looking at the whole person, including the nutrients in their body --

A. Yes.

Q. -- because we know how much that can affect a person?

A. Yes, their diet, I think, is a massive part of it as well because, as well, when they're put on these -- on all the medication, surely if you're not eating very much, does that medication perhaps react different to --

Q. Differently --

A. -- if you had a full belly. It would absorb the medication more? I don't know because I'm not professionally medical but I would have thought that

eating was quite an important part of, you know --

Q. The care of someone?

A. Yes, and getting better, and we all know we can be a bit hangry if we've got an empty belly.

Q. Yes, indeed. Secondly, you go on to say that every patient should have a care plan that is individualised and patient specific?

A. Definitely.

Q. Now, in Ben's case, he didn't have one at all?

A. No.

Q. But what you are focusing on, I think, and you must tell me if I understand wrongly, is that mental health is so individualised --

A. Yes, very, I think.

Q. -- and that you consider that it has to be patient specific.

A. *(The witness nodded)*

Q. And that it has to be regularly reviewed and updated --

A. Yes.

Q. -- and in particular, changed if something is not working?

A. Yes. It's because I think what they may need when they're admitted, a week or two later, perhaps with medication and if they've gone in psychotic and they're calming down a bit, they may not need that as much --

Q. Yes.

A. -- or it could be the opposite way round and they need more.

Q. Yes. You also, then, talk about -- and this is a theme that, Lisa, I know you've been following the Inquiry a little, we have heard from family after family -- you concentrate on the engagement with families and how crucial it is that families should be kept up-to-date and fully informed?

A. Yes, but it doesn't seem that -- well, in my experience, it doesn't seem they want to. They seem to -- they just want -- "control" perhaps isn't the right word -- of the patient with no outside input or interference or complaints whatsoever from friends or family.

Q. Do you feel that it's, in your experience as you're describing it, that it's a defensiveness?

A. Yes, I think they're perhaps worried of what family, friends and relatives may see or find out and, yeah.

Q. And a reticence to be questioned about the way in which care is being carried out?

A. Yeah, I think it's almost sort of "How dare you question the way we work?", really, rather than actually asking "What are your concerns?" And, you know, no one ever sat with me and asked me if I'd even got any concerns.

Q. No. As I understand it, no one asked you for any

background to Ben's life?

A. No.

Q. Any information about what might help him to be calm when he wasn't?

A. No.

Q. What trigger points might be?

A. No. I mean, one time I went to visit and Ben would push on the buzzer to try to get back onto the ward. If no one answered, he'd push again, and again, and again. His finger would just be on that buzzer and it probably -- I admit, it probably drove them nuts. But rather than talk to Ben about that, they actually said to me, "Can you ask him to stop keep pushing the buzzer please, every time he wants to get in". I said, well, that's the wrong approach to take with Ben because if you tell him really not to do something, he can't help it.

Q. He'll do it?

A. He'll do it even more but he's not doing it either on purpose to ignore you. That's his lack of patience, perhaps, I suppose.

Q. Yes, yes. He needs something to happen now.

A. Sort of look, "I'm here, I want to get in, let me in now". But there was no understanding of that about him. You know, had they put that in his care note?

Q. And no one spoke to him about it; instead they spoke to you?
A. Yeah, "Can you tell him to stop pushing the buzzer, we'll let him in when we get a minute".
Q. "When we can". The other thing you say is that, because you were aware -- because obviously Ben was an adult, and one of the things you say is that, if ward staff don't have the consent of a patient to update the family, then nonetheless and at the very least, they could seek input from the family without breaching confidentiality?
A. Yes, yes. I think there still should be input from people that know that person better than anybody else --
Q. Yes.
A. -- what they're like, you know, what might trigger them, what may calm them, what -- you know, pushing the buzzer: that is just how Ben is. He's not doing it to be annoying or rude, or ...
Q. In your view even where an adult patient is not consenting to a family receiving information, a young man like Ben, who had a supportive and loving family network, had a number of individuals who could have assisted staff in their care --
A. *(The witness nodded)*
Q. -- by setting his life in context and explaining him as

a person and how his mind worked?

A. Yeah, yeah.

Q. Lisa, you go on at the bottom of the page to make suggestions for recommendations about recruitment practices. Tell us about that.

A. Well, I think it would help if staff were permanent staff.

Q. Yes.

A. In Ben's case, he's in a lot of -- a lot of what I've seen since in the Inquiry, there's so many agent staff, there's so many new faces, so kind of -- the patient never gets used to or comfortable with a member of staff. There's a lack of --

Q. Continuity of care?

A. Yes, yeah. And I'm not sure if the -- is it the CRB? All them checks. I'm not sure if they're done or done properly.

Q. Background checks on staff?

A. Yes.

Q. Is that what you mean?

A. Yes, yes.

Q. Yes. If we go over the page in the same vein, you talk about training for staff, ongoing training --

A. Yes.

Q. -- including basic physical healthcare knowledge and

CPR?

A. Yeah.

Q. It seems so obvious: you're recommending that staff be properly trained in how to care for mentally unwell patients.

A. *(The witness nodded)*

Q. Tell us a little bit more about why that's one of the things you've set out?

A. Because I think the staff that were caring for Ben weren't trained or, if they were, it wasn't enough. I think again it's in a statement, they knew nothing about ADHD. Well, if you know nothing about ADHD why are you working in a place that has people in there that have ADHD?

Q. Yes.

A. How can you work with someone if you don't understand or know --

Q. The condition.

A. -- anything about it? So yeah, that's one of the reasons.

Q. Then next you go on to say that you consider it important that staff themselves receive appropriate support?

A. Yeah. I think that's also really important. I should imagine it's a really, really difficult job to do.

Don't get me wrong, I loved Ben, I adored Ben, but his head was such a muddle sometimes that it would make my head such a muddle too and it must feel similar for staff.

Q. Yes.

A. You know, I think any nursing job now, and perhaps especially mental health or dementia, jobs like that are really, really hard going.

Q. Very challenging?

A. Yeah.

Q. Yes.

A. And if you don't look after the staff, then --

Q. The quality of care is going to be affected?

A. Yes.

Q. Yes. You go on to say that you think staff should be incentivised through a proper career structure and training programme and proper recognition and reward for good practice?

A. Yes, and from -- again, from reading all Ben's -- some of it is just hearsay since he's died, it seemed the ones that are trying to do a good job, they want out. And it just leaves the not-so-good staff there to just really do what they want and get away with it. But anyone that's sort of flags up any sort of concerns seems to be pushed out, bullied by the staff, called

a grass, unfortunately.

Q. I think, leading on from that, what you say at paragraph 145 is that you think change -- what is required, is a "fundamental cultural shift from the top down"?

A. Yeah, absolutely. Yeah.

Q. As part of that particular recommendation, you say that you consider that each institution should have a governing board that includes both family members and people with lived experience of mental health care?

A. Well, yeah, I think that would be a great idea, really. I think, as well, there should be mutual people that visit and perhaps could do just complete random spot checks on these wards, and I think patients are more likely to talk to someone who perhaps isn't one of a member of staff, as such. They perhaps need someone that they can put their concerns to that will then deal with that for them, rather than --

Q. As an intermediary, almost?

A. Kind of, yeah. Rather than them having to go to a member of staff that's perhaps been a little bit hostile towards them, or -- I mean, how can you feel comfortable enough to tell someone your feelings and your thoughts when they're not really that friendly? But I think if there was more friendly faces that are

completely mutual, I think it would help a lot.

Q. Thank you. At the bottom of the page, you say that you consider that there must be a zero tolerance approach to all forms of abuse?

A. Yes.

Q. With proper accountability and, where abuse is proved, that it should result in immediate dismissal and referral to the police?

A. Yes, but it does seem that if a member of staff does seem to flag anything like that up, like I say, the next minute they're gone.

Q. You then say -- and this is thinking back to April 2008 and thereafter, when you and Ben's grandmother took him to A&E, and that was on each occasion problematic, and on each occasion he was sent away, what you say at the top of page 57 is that you think we should have dedicated mental health A&E treatment units?

A. Yeah, I think that would benefit A&E, because it would take the mental health part of things away from such a massive busy A&E right now, and then also for the patient, they're sitting with people that are perhaps trained more in mental health and they've got more of an understanding of their behaviour or if -- you know, anything. They could be shouting, they could -- and they're not punished for it. There's someone to

actually sit, "Come on, come on now, tell me what's wrong", who is trained. Rather than just again looking at them like a nuisance --

Q. Call the police.

A. -- having security or police take them out when they're there for a reason.

Q. So a space that is more suited to those in mental health crisis --

A. Yes.

Q. -- with staff who are trained to recognise that difficult or aggressive or agitated behaviour --

A. Yes.

Q. -- have underlying mental health causes and can deal with that more comprehensively and in a more therapeutic way?

A. Yes, yes, because to someone that knows nothing about mental health, which a lot of staff in A&E, they're just not trained -- they're trained to do what they do, and the mental health side of it isn't doesn't come into their -- I don't know whether they do it at college or whatever, a little bit of it, or at uni, but to someone that understands, they would be able to see that person over there perhaps kicking the skirting boards or swearing a bit, say, "It's fine, it's fine, they're not going to hurt anyone, they're just perhaps releasing how

they feel and they're perhaps a little bit psychotic or" --

Q. Yes, these are symptoms?

A. Rather than, "Oh, my God, they're trouble, get them out".

Q. Yes, yes. Then, Lisa, last, if you look at paragraph 148 on page 57, you say that you think there should be formed a genuinely independent body with responsibility for oversight of all mental health care facilities?

A. Yes.

Q. Tell us a little bit more about that?

A. That's where I say I think it would be a great idea if there was, like, a board of people that could go and do spot checks, 2.00/3.00 in the morning if they want. They could walk onto that ward and they could really see what's happening.

Q. Yes.

A. Not a CQC check or, as it used to be, health and safety check, whereas they're given two or three weeks' warning that they're coming. Well, of course, they're going to have it up to scratch as much as they can, knowing that someone is coming to scrutinise notes and ligature points and -- whereas if people were allowed to go any time of day or night --

Q. In an unscheduled way, yes.

A. -- what might they see or find?

MS TROUP: Yes. Lisa, I have come, I think, to the end of my questions for you.

Chair, do you have any further questions for Lisa at this stage?

Questions from THE CHAIR

THE CHAIR: I've got one further question. You talked about how unsettled the ward was on 28 December and about the staff who had gone home early, notwithstanding that the ward was unsettled. Was the ward, so far as you were aware, often like that: unsettled? Did it have a high proportion of people who perhaps made it feel less calm on it?

A. Well, I don't know about other patients but, from their records of Ben, he was unsettled every single day and, you know --

THE CHAIR: Yes. I just wondered whether he was unusual in that respect, whether there were many other patients as challenging as Ben?

A. Yeah, I didn't really --

THE CHAIR: He didn't say anything?

A. -- see any other patients or communicate with any other patients, but their account of Ben is that he was pretty much always a nuisance or trouble or -- so, to me, the

ward was probably always unsettled while he was on it. There was nothing different, really, about the 28th when he died. By their account, he'd been like that before.

THE CHAIR: Thank you.

MS TROUP: Lisa, we're now going to see -- I think we have got six photos of Ben and we're going to put those on screen, all right?

If we could have those up, please.

THE WITNESS: Thank you.

(Photographs displayed)

MS TROUP: Is that Ben's grandmother?

THE WITNESS: Yeah, my mum.

MS TROUP: Yes.

THE WITNESS: That's the chain. That's a big chain.

MS TROUP: Yes, I remember you referring to it. Thank you. Yes.

THE CHAIR: Thank you.

THE WITNESS: Thank you.

MS TROUP: Lisa, thank you. What will happen now is that we'll ask you to stay in the building, not here, but in the building, just for about ten minutes and that's so we can ensure that any other questions for you come to us. Thereafter, if there are no questions, you're free to go.

THE WITNESS: Thank you.

MS TROUP: Chair, I think we'll then sit in the next public session tomorrow morning at 10.00 am.

THE CHAIR: Tomorrow morning then at 10.00 am, and can I thank you very much for your evidence.

THE WITNESS: Thank you.

(1.08 pm)

(A short break)

(1.17 pm)

CASE MANAGER: There are no further questions for this witness, so we will reconvene tomorrow morning at 10.00 am.

(1.17 pm)

(The Inquiry public hearing adjourned until 10.00 am the following day)

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