Name of witness: Stuart Ringer
Statement No: 1
Exhibits: 3
Date:24.04.2025

LAMPARD INQUIRY

WITNESS STATEMENT OF MR STUART RINGER

I, **MR STUART RINGER**, date of birth [I/S], of [I/S] [I/S] will say as follows:

1. I make statement pursuant to a Rule 9 Request for evidence received from the Lampard Inquiry dated 30th January 2025, in relation to Malgorzata Elzbieta Breczko-Nowak.

2. For clarity Malgorzata is a Polish name, which is shortened to Gosia. This is the name that I always knew the deceased by and that I will use throughout my statement.

3. In my letter dated 16th April 2021 to [I/S] the head of the Chelmsford & Essex Centre, I have set out in detail how I first discovered Gosia suffered MH and addiction issues, her first contact with MH services in both London in 2010 and then in Essex at the start of 2012. This letter is attached to this statement as **Exhibit "SR1"**

4. Details of the development and circumstances of Gosia's mental ill-health can also be found in **Exhibit "SR1".**

5. To the best of my knowledge Gosia received no formal diagnosis, either spoken or written. As her primary carer and next of kin, I was given no diagnosis. Please see **Exhibit "SR2"** in which I express my concern that I have not being given any form of care plan after Gosia`s release from Peter Bruff Ward on 5th June 2019. I was also not given a medication plan at this point, or any point.

6. To the best of my knowledge, there was never an occasion where I or anyone else considered that Gosia should undergo a mental health assessment in

relation to a mental health admission for inpatient treatment and care and treatment that did not take place.

7. On 23rd May 2019 Gosia had a meeting with **care co-ordinator A** and Dr **[I/S]** **[I/S]** at the Chelmsford and Essex Centre, which I attended. At this meeting Gosia made it clear to all parties that she wanted to be admitted to the Peter Bruff unit, stating *"I just can`t control my mind",* she also asserted that she was a having suicidal thoughts and stated that "I have enough medication to do this". She was not admitted until 25th May. Neither of the HPC present seems alarmed at Gosia`s statements.

8. I was not advised when Gosia would be admitted, it was left to Gosia to call me to advise of when this happened. Her care co-ordinator **Care co-ordinator A** did not communicate with me at all.

9. Gosia was at Peter Bruff for 10 days, until 5th June. I visited Gosia while she was at the unit. She seemed much more settled and commented that she felt she was being listened to and felt heard about her issues. I spoke with a nurse at the time, as Gosia was due to attend Broomfield Hospital for a follow up appointment in relation to a gallbladder issue she had had earlier in the year. The appointment was for 5th June 2019 and I was told that the unit had made arrangements to transport her for this appointment. Given Gosia`s ongoing MH issues I assumed that she would be brought back to Peter Bruff after this outpatients appointment. I was informed that once *"discharged"* she would not be brought back. I found this alarming and Gosia showed signs of anxiety when informed that this would be the situation.

10. When I visited Gosia on Bruff ward my impression was a good one, the staff seemed engaged and caring. My visit was a brief one, and I am unable to comment any further on whether the ward and building were a suitable environment in which to provide inpatient mental health care, or whether the ward environment met her basic needs.

11. Gosia seemed satisfied to be at the ward. The issue was why was she not taken back there after her outpatient appointment at Broomfield on 5th June 2019?

12. To the best of my knowledge Gosia had no input to her care plan. I do not consider that the level of engagement with Gosia about decisions and plans in relation to her care and treatment were appropriate. As her primary carer and the person responsible for funding her life (she was not in receipt of public funds) as well as housing her, I was not included in any care or medication plan.

13. At no stage did I believe my involvement was adequately considered. In fact, I would go as far to say that it was a conscious decision to exclude me for the care plan.

14. In terms of my concerns about the formulation and implementation of Gosia's care plan, please see **Exhibit "SR1"**. My letter sets out with full openness, the failing I witnessed and experience in Gosia`s care and what I believe to be an abuse of power and coercive behaviour of the MH teams at both Brentwood in 2013 and the Chelmsford in 2019. I have never had a response to this letter.

15. The only treatment that was offered to Gosia was medication. No one ever took the time to ask what was at the root of her pain. No diagnosis was ever given to me.

16. My views on Gosia's initial and later treatment, or lack of the same, can be seen in **Exhibit "SR1"**.

17. I do not think that decisions about Gosia's mental health treatment were appropriate. She was discharged against her will on 5th June 2019. The reason for discharge was to attend and outpatients appointment at Broomfield Hospital. Given that she had expressed suicidal thoughts in her meeting with her care co-ordinator on 23rd May 2019, I do not believe a 10 day stay at Peter Bruff was sufficient.

18. To the best of my knowledge, no therapeutic care was offered to Gosia. However I had paid for her to have private physiotherapist in 2018 to help with her addiction issues.

19. I do not think the care for Gosia's mental health was adequate. In fact I believe that her care co-ordinator was acting in a way that made her anxiety much worse. It is my belief that **care co-ordinator A** acted in a coercive manor and put pressure on Gosia to make allegations against me. After a meeting with **[I/S]**

care co-ordinator A Gosia told me that this individual had suggested to her she should to accuse me of harming her. **"Exhibit SR3"**

20. I am unable to comment on the medication given to Gosia as I was not given a medication plan. The result of this is that Gosia was often unaware of when she should take her medication, how much she should take and whether she had taken it. Throughout the 9 years I looked after Gosia, I had witnessed doctors and other HCP`s prescribe medication that she was told she should not mix alcohol with. When I have pointed out that she is an alcoholic and she WILL drink, these HCP have just wagged a finger and told her not too. There seems a complete lack of understanding in the NHS of what addiction does.

21. In terms of Gosia's safety as an inpatient, it is my belief that during her stay at Peter Bruff in December 2018, she was physically assaulted by another patient. I only have anecdotal evidence that Gosia gave me at the time. Gosia was asked if she wanted the police involved and she said no.

22. Gosia was an inpatient at Peter Bruff for 10 days as of late November 2018 to early December 2018. I cannot be specific on the dates. She was transferred from Peter Bruff to Broomfield on 5th June 2019, for an outpatient appointment in relation to a gallbladder issue.

23. I was not included at any stage of the discharge process, so cannot comment on whether Gosia had any involvement.

24. I had no input on the decision to discharge. I did however make it clear to the staff at Peter Bruff on 30th May when I visited Gosia, that discharging her because she had an outpatients appointment at Broomfield on 5th June, was inappropriate and premature and that I believe this should not happen. I was not informed of further action.

25. I was informed on by Gosia herself on 5th June that she was at my property. I was not given any information by Peter Bruff of Gosia`s care co-ordinator. There was no discharge plan in place as far as I was aware.

26. No information was ever shared with me about a discharge plan or arrangements for care in the community. Please see **Exhibit "SR2"** requesting such information. I never received an answer or acknowledgment of this letter.

27. I have deep concerns about the discharge process. It is my belief that Gosia was released purely on the basis that she had an outpatients appointment at another facility and had nothing to do with her mental condition and ability to function in life. She had been desperate for care when she attended her **meeting with care co-ordinator A** of 23rd May. She did not want to leave the unit and left confused and bewildered as to why she had been discharged. It is my belief that if she had been kept in for a more appropriate amount of time, she may still be alive today.

28. In respect of the lack of communication I experienced I refer again to **Exhibit "SR2"**, in which I have requested to be included in Gosia`s care plan and have requested a meeting to discuss this. I received no reply to this request. As Gosia`s primary carer, I believe it was not only unprofessional, but a dereliction of duty to not include me in her care. As I have set out in another reply, I assert that **care co-ordinator A** was using coercive behaviour towards Gosia and encouraging her to make false allegations against me, with the aim of placing her in somewhere called Safer Places. I believe this goes back to the events of June 2013, which I have set out in **Exhibit SR1**. I assert that members of the Brentwood MH team made false allegations against me, so that they could place Gosia in a similar facility in Harlow. I believe this to be an abuse of power.

31. Gosia was showing signed of mental and physical breakdown at the end on November 2018, at which point I called an ambulance. She was taken to hospital and according to a telephone conversation I had with Gosia, she was advised by the MH team that they wanted her to attend the Peter Bruff unit. She agreed to do so of her own free will.

32. I believe that level of engagement with Gosia was appropriate. However I was concerned at the meeting I attended on 23rd May 2019, that the healthcare professionals in attendance, shown great resistance to Gosia`s request to be admitted back to the unit, even when she discussed suicidal thoughts.

33. I was able to visit Gosia when she was an inpatient, I didn't feel there was any issue when she was in Peter Bruff. I was not given any information as to how to raise any concerns that I might have about her safety, but I did not and do not have any issue with the inpatient care provided at Peter Bruff. It was the

care and communication when she was under the care of Chelmsford & Essex Centre that appears to be the issue.

34. I made numerous complaints setting out my concerns about the treatment provided to Gosia (see **Exhibits SR1 – SR3**) but to date I have never received a reply from the issues I have raised.

35. I received no communication or support after Gosia`s death. Even when I have written requesting information, I have been greeted with a wall of silence and complete inhumanity. **The head of the Chelmsford & Essex Centre and care co-ordinator A have** many questions to answer, which I have set out in my covering letter addressed to the Inquiry dated 28 March 2025.

36. As far as I am aware no investigations of any sort were undertaken after Gosia's death.

37. It is a sad indictment that I cannot say any positive words about the care Gosia received, other than my comments in paragraph 10 above in relation to Peter Bruff ward. What happened to Gosa is I'm afraid appalling and a disgrace upon this country and the NHS.

38. Gosia felt that **care co-ordinator A** was being coercive in her attitude to her living at my property. It is my belief that this behaviour by **care co-ordinator A** led to heightened anxiety in Gosia and led to her drinking again.

39. In my view, Gosia should not have been released from the Peter Bruff ward after just 10 days. She was clearly vulnerable and in need of an extended period of care. I also believe that her care co-ordinator contributed greatly to her fears and anxiety. **Care co-ordinator A** seemed more concerned with blaming me for Gosia`s problem, without ever taking the time to understand what was the underlying issue in Gosia`s life; that she was sexually abused as a child.

40. Frankly I believe the NHS is not fit for purpose when it comes to mental health. I`m sorry but I do not have an answer to this, however I am aware that currently the system lack empathy in any meaningful way. Too much of the care it farmed out to charities, who do a great job, but have limited resources and remits. I have recently trained as a mental health first aider and as such

my job is to direct people towards the care that they need. I cannot in all good faith direct people towards anything that involves the NHS. I have zero trust in this organisation. It has failed my friend and placed a stain on my character that I cannot remove. They have blamed me and countless other people that care, for being the issue, when all we are doing is our best in difficult situations that we are not trained for. I say to the powers that be; How dare you! How bloody dare you!

Statement of Truth

I believe the content of this statement to be true.

SIGNED ..... [I/S] .....

MR STUART RINGER

DATED..... 24/4/25 .....