WITNESS STATEMENT OF KAREN MICHEL
PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

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1. I, Karen Michel (**[I/S]** **[I/S]**) am the sister of Marion Michel (DOB: 5th August 1965 and DOD: 4th March 2022).

2. I am making this statement based on my recollection of events from my conversations and visits with Marion during her admission at Brockfield House and the documents that I had sight of in preparation for Marion's inquest and in response to the Inquiry's Rule 9.

Mental and physical health history

3. Marion had a number of physical health needs, as the PSII highlights at Page 16:

   'Marion had a physical health history of; Glandular fever (diagnosed 1983), Myalgic Encephalomyelitis (diagnosed 1988), total splenectomy (2004), atopic dermatisis (diagnosed 2006), lipoma of thigh (January 2018). She also had chronic hay fever, hypertension and a BMI of 38.9.'

4. Marion's first contact with mental health services in Jersey was in 1984, when she was 19 years-old. Marion was referred by her GP after she attended reporting tiredness, lethargy and appetite disturbance.

5. Initially it was considered by psychiatrists in Jersey that Marion was moderately depressed, and she was mainly treated with anti-depressants. There seems to have been a brief period when bipolar disorder was considered as a diagnosis, but this did not last.

6. Marion's first admission to a psychiatric ward was in April 1985 at hers and our mother's request, but she discharged herself after three days.

7. By August 1988, Marion was asking to continue anti-depressants although by then chronic fatigue syndrome and ME were being considered.

8. In 1996, at a psychiatric review Marion reported exhaustion, sleep disturbance and wild dreams. She advised that this had started again in March 1995, and she had been off work since June 1995.

9. In 1998, when Marion was 33 years-old, she reported her first signs of psychosis, paranoid thoughts and as presenting as actively suicidal. She was admitted to the psychiatric hospital in Jersey and seemed to improve on taking anti-psychotic medication. I understand that the PSII notes at Page 16 that Marion was admitted to *'Chausey Ward (Jersey) for about eight weeks'.*

10. Marion was doing well there and was given some home leave. Marion then absconded from the hospital and went missing for around five to seven days until she presented in Norwich where the police were involved due to her paranoid presentation. Marion later told us that she had flown to the UK via Guernsey under a false name and then slept at the airport. Marion was then returned to psychiatric hospital in Jersey for a few weeks. It was at this point that Marion was diagnosed with schizophrenia. It is noted that Marion accepted that she had 'paranoid psychosis', but not schizophrenia at this time.

11. In September 1999, Marion stabbed her then partner in the back with a large kitchen knife while he was sleeping. She was noted by her partner to have been quieter than usual and behaving oddly in the days and hours leading up to the attack as well as having watched a violent film just prior to the attack. When arrested, Marion was also found to have bruises and marks on her which she said were due to domestic violence. Marion presented as psychotic at the time of the attack. Marion's diagnosis of paranoid schizophrenia appears to have been confirmed around this time.

12. Marion was subject to court proceedings because of this assault. She was ordered to spend a few weeks in psychiatric hospital and received a community disposal. I understand that the PSII details this at Page 16: '*She was admitted to hospital as a voluntary patient and given a diagnosis of Bipolar Affective Disorder. She was bound over and did not receive a custodial sentence. As her condition improved, she was discharged at her request on 27th September 1999. Her medication was later changed to Amisulpride due to concerns about weight gain on Olanzapine.'* In respect of the

bipolar disorder diagnosis, as mentioned at Paragraph 5, to my knowledge Marion did not end up with this as a confirmed diagnosis and I cannot recall ever discussing a potential diagnosis of bipolar in respect of Marion.

13. In 2001, two incidents occurred which led to Marion's brief admissions to psychiatric hospital. In April 2001, Marion developed paranoid thoughts while she was dealing with issues relating to the sale of her flat. In July 2001, Marion sat on the ledge at the top of a multi-storey car park for a long period but was eventually talked down. She denied suicidal ideation. Marion accepted a referral to a psychologist; however, I cannot find any evidence that she ever had a psychological assessment in Jersey.

14. In February 2002, there is a record of an overdose of sleeping tablets. In May 2002, it is noted that on psychiatric review that there was no evidence of depression or reoccurrence of psychosis, however that the chronic fatigue syndrome had returned.

15. In July 2002, Marion stabbed herself in the chest and abdomen using a kitchen knife. This happened on the balcony of her new flat that she shared with her then partner. Her neighbours saw her and called the emergency services. When the emergency services arrived, Marion panicked and jumped off the balcony of her **[I/S]** flat, **[I/S]** She required two corrective surgeries. Afterwards, it was noted that Marion had acted in response to delusions; she described going from being normal to psychotic in about three to four minutes. I understand that the PSII notes at Page 16 that her then partner and our family, by which I assume the author means our parents, *'reported that during the previous 24 hours she had been a little subdued.'* It was noted by Marion's psychiatrist that she may be masking some psychotic symptoms.

16. In May 2003, Marion jumped out of the window of her **[I/S]** flat, causing significant spinal injuries and a ruptured spleen which was subsequently removed. She had surgery in Jersey and then was transferred to Southampton Hospital for further spinal surgery before being transferred back to Jersey General Hospital.

17. This appears to have been brought on by stress in relation to some problems with a company that she believed had swindled her. I understand that it is noted in the inquest bundle that: '*In 2003, Ms Michel tried to organise some furniture but she reported that the furniture maker had 'scammed us for £5000' and, resulting from trying to sort this out, she felt stressed, and one morning woke up and jumped out of the window from*

their flat **[I/S]** *and reported feeling the same type of stress she had in the car park.'* **[p. 97, Inquest Bundle 3].** Around 15 years later, it emerged that there had been significant changes in her relationship with her then partner which may also have been stressful for her around this time too.

18. Marion spent two months in hospital after this and took longer to recover physically. I recall that her psychiatrist noted that it was difficult to decide what to do to try and stop a further relapse given the sudden onset. He retained her on a higher dose of anti-psychotic medication until October 2004 when he agreed to reduce it following ongoing complaints from her of over-sedation. Marion then returned to live at the family home, eventually moving into the annexe there.

19. Marion continued to be known to mental health services after this. She had regular visits from a community psychiatric nurse and from a worker who took her out for trips and activities. She also started to do some part-time work through a local work scheme. Marion had regular reviews by her psychiatrist who she had a positive relationship with and had treated her since the 1990's, but who retired around 2008 or 2009.

20. In 2010, Marion was discharged from the mental health services to the care of her GP. Marion continued the same medication prescribed by her GP from 2010 onwards.

21. In 2014, I understand from **Dr A's** chronology that Marion attempted suicide. I do not know anything about this incident and I was not aware of this.

22. In August 2018, Marion stabbed her then partner. This was again a sudden and unexpected event. Afterwards, it was discovered that there had been some major changes in their relationship which appears to have caused Marion some stress and a change to her normal routine. Marion was also fearful of abandonment and what this change would mean for her relationship with her partner. Marion was remanded in custody following this incident.

Mental health assessment

23. Following the 2018 assault, Marion was remanded to La Moye Prison in Jersey and was subject to lengthy criminal proceedings. This was a big shock to Marion.

24. Since arriving at the prison, Marion had also been taken off her sleeping tablets. She had been on those tablets for over 20 years. So in prison, she had gone completely cold turkey. I understand that she pleaded with the authorities to be given the tablets because she could become unwell, but they did not give her the tablets.

25. Several psychiatric assessments were commissioned from three psychiatrists representing the Crown and the defence to assist the court with the issue of Marion's mental capacity at time of the offence and to assist with the court's sentencing exercise.

26. **Dr B** a consultant forensic psychiatrist at EPUT's Brockfield House, was involved in the proceedings. I am not clear if this was because Jersey mental health service used this facility or because it was recommended by one of the experts for the defence, **a Professor** I recall being told that **Dr B** had been a trainee under the Professor. The experts recommended further assessments of Marion at a specialist secure facility, being Brockfield House in Essex. In November 2018, the court approved of this.

27. I believe that Marion was advised about this transfer by her solicitor. I am not sure who else spoke to her about this. I am not sure if the date of the transfer was clear at this point or was dependent on there being a space available.

28. On 22nd November 2018, Marion cut her neck, wrists and feet **with a sharp item** in her cell. She required emergency surgery and intensive care treatment at Jersey General Hospital. Marion later said that she had done this as she had been told she would be going to Brockfield House in the UK and that she was scared to go and to leave the island. I do not believe that Marion had any sense of where she was going.

29. On 4th December 2018, Marion was discharged back to La Moye Prison from Jersey General Hospital, where she was then subject to additional restrictions.

30. Once I knew more information about where Marion was transferring to, I read the latest CQC inspection report regarding Brockfield House, and tried to reassure Marion about it and that it was a better than being in prison where she was not getting any help or support. I did not know about the issues and concerns regarding EPUT's services until after Marion died.

31. On 20th December 2018, Marion was transferred to Brockfield House without incident. She was admitted to Fuji Ward, a 12-bed female medium secure ward. This was initially for a 12-week inpatient assessment at the unit under the Mental Health Act 1983 (as amended in 2007) and she was still on remand.

32. Around 20 December 2018, I had gone to visit my parents over Christmas with my own family. I had a call from my sister's first social worker at Brockfield House a day or two after Marion arrived, introducing himself and to arrange for me to visit Marion after Christmas. He explained what ID I needed to bring with me. I first visited her about a week after she had been admitted. My visit was supervised by a staff member as Marion was still under constant 1:1 observations.

33. Marion told me that she realised that the environment at Brockfield House was so much better for her than prison as she did not have to have the cell door shut on her. She was also aware that there were activities that she could join in with which she was pleased about. A few weeks later I received an information pack about Fuji Ward, although this was mainly aimed at patients.

34. Following the end of assessment, it was agreed that Marion would remain at the unit until the end of proceedings and would be involved in the rest of the proceedings virtually. Therefore, once she left Jersey in December 2018, she never went back.

35. On 16th September 2019, the court case against Marion concluded. I understand that Marion was given a Section 37 Hospital Order with Section 41 Restrictions. The order could not be discharged or transferred and Marion could not be granted any leave of absence from Brockfield House unless by the order of the Jersey Court. **Dr B** would then provide a psychiatric report on Marion's presentation and treatment to the Jersey court every six months.

36. For completeness, I believe that it was during Marion's proceedings that Jersey designated Brockfield House as an 'approved establishment'.

Diagnoses

Specific illnesses

37. When Marion was first assessed at Brockfield House, the assessing consultant forensic psychiatrist, Dr B agreed with the existing diagnosis of paranoid schizophrenia and that this was in remission and had been for some time, having been well controlled by medication. **[§6.1.1 Addendum Psychiatric Report of Dr B 11th September 2019].**

38. I understand that Dr B's assessment was based on his reading of Marion's mental health history, the expert reports prepared for the court case, and meetings that he had held with Marion.

39. He noted that Marion showed some negative symptoms of schizophrenia such as the deterioration of her personality, and at times self-neglect and a lack of empathy. Dr B [I/S] initially considered that: *'Ms Michel is clinically quite a complex case. In my view, her presentation cannot solely be explained by a psychotic illness. I believe Ms Michel also suffers from Mixed Personality Disorder, with features of Emotionally Unstable Personality, impulsive and borderline type and Schizoid Personality.'* **[Paragraph 9.1.5, p. 39 Inquest Bundle 3, Psychiatric Report, 29 April 2019, Dr B]**

40. A full psychological assessment was also completed by a senior forensic clinical psychologist, Ms C. She was the ward psychologist for Fuji Ward. I understand that this assessment included eight sessions with Marion, between January to April 2019.

41. Ms C also drew on Care Programme Approach (CPA) assessment reports completed by other staff at Brockfield House, including those in nursing, medics, occupational therapy, social work, and psychology.

42. As part of her assessment and with Marion's permission, Ms C arranged to speak to me. We had a long telephone discussion on 17th April 2019 and I was asked questions about Marion's childhood, mental health history, relationships, personality and functioning, and what I knew about what had led to the recent assault.

43. As a result of these tests, the forensic psychologist found that Marion had some traits of emotionally unstable personality disorder, but these did not amount to a full diagnosis of EUPD. She also found some traits of schizoid personality disorder.

44. **Ms C** also differed in view initially to **Dr B** in that her assessment was that Marion's assaults on her partner and her self-harm arose from psychosis linked to her schizophrenia **Ms C's** view was that Marion was triggered into brief psychosis by stressors and failures to problem-solve, noting a *'quick to relapse to psychosis'*. **Dr B's [I/S]** view was that Marion's 2018 assault differed to the assault in 1999, in that she was not psychotic on that occasion and that there was no link between the 2018 offence and her schizophrenia **[§9.27, Dr B report, 29th April 2019].**

45. Towards the end of the court proceedings, **Ms C** changed her view and found that Marion had not been psychotic at the time of the 2018 assault, or when she self-harmed in prison.

46. I believe that this information was poorly managed by **Dr B** going forward, in that this was not effectively relayed. I think this led to confusion amongst the staff caring for and treating Marion. The confusion was around the nature of Marion's relapses.

47. **Dr B** and **Ms C** agreed that Marion displayed traits of EUPD alongside schizophrenia which was in remission and so this was her final diagnosis. **Dr B** summarised his view in an **Addendum Psychiatric Report dated 11th September 2019 at §§ 6.1.2 – 3**:

I remain of the view that Ms Michel has marked abnormal personality traits, specifically features of EUP of both borderline and impulsive types. She has displayed features of mood instability, a marked tendency to act impulsively, series of self-harming behaviours to relieve inner tension, extreme fear of rejection and abandonment. I'm now less convinced with the features of schizoid personality as I believe these features are related to her chronic schizophrenic illness as it is well recognised that schizophrenia can lead to some alteration/deterioration in personality.

Furthermore, the psycho metric testing had also concluded that Ms Michel presented with the traits of borderline personality disorder but did not meet the diagnostic criteria for EUPD. In my view, whether these abnormal personality traits amount to a full Personality Disorder or not, is merely an academic discussion, as it is evidently clear that these traits are highly relevant to describe her previous clinical presentation, namely her history of serious self-harming behaviours, the formulation of current offending, her future risk of violence and need for ongoing inpatient treatment.'

48. Dr B, in his report on 13th September 2019, noted: *'Ms Michel suffers from Paranoid Schizophrenia, which has been in remission for several years. … I believe Ms Michael also has exhibited traits of Emotionally Unstable Personality Disorder of both impulsive and borderline types.'* **[From p. 58 Inquest Bundle 3, Psychiatric Report, 13 Sep 2019, Dr B].**

49. Dr B provided a witness statement for the inquest into Marion's death, which was heard in 2023. In his statement, he noted, *'I remain of the view that Ms Michel suffered from [s]schizophrenia, which was in remission. … [Marion also] had features of Emotionally Unstable Personality Disorder traits not amounting to full disorder. The team recognised this diagnosis and therefore she had completed Dialectical Behavioural Therapy (DBT), which is a first line treatment for this disorder'* **[Dr B Witness Statement, 22nd May 2023].**

50. It is worthy to note that Mr D Marion's psychologist, said in his witness statement for the inquest, that, *'[i]t seemed that it was agreed by the Fuji MDT, at the time leading up to her index offence, that her psychotic breakdown (relapse) was most likely the primary 'driving' factor leading to Ms Michel stabbing her ex-partner,* [R/O] Mr D did not give live evidence at the inquest so this could not be tested further with him **[Page 122, Inquest Bundle 1].**

Autism spectrum disorder

51. Marion completed the Adult Autistic Spectrum Quotient test as part of her initial psychological assessment. Marion scored slightly higher than average in this test suggesting some autistic traits **[p. 81, §43,** Professor **report, 20th November 2018].** In the Cambridge Behaviour Scale, which was set to test her empathy, her score was at the low end of average. Therefore, a full ASD assessment was completed using the Autism Diagnostic Observation Schedule (ADOS). I am not sure exactly when this took place, but I believe it was in 2019 when Marion was on Fuji Ward. I have not had sight of this assessment.

52. I am aware that the conclusion was that Marion did not have ASD, but I do not know whether there were any further comments on her profile or recommendations made for working with her.

53. It is unclear whether staff looking after Marion were aware of these tests having been done or their results. The EPUT investigators claim to have read all the reports and records about Marion, but they did not mention anything about this assessment taking place in their report. My assessment and review is that the only staff member that mentioned this in their statement to the coroner was the Occupational Therapist **Ms E [I/S]** who had known Marion since her admission. This leads me to believe that this was not kept in mind by staff at the unit.

54. From my perspective as Marion's sister, I do believe that Marion did have some ASD traits. For example, routine was very important to her and she found it difficult to deal with change. I think she also lacked the social skills to understand how her bluntness, on occasions, could come across to others.

Problem-solving difficulties

55. In the reports provided to the Jersey court in 2018 and 2019, there are several references to Marion having difficulties with problem-solving. For example, **Dr B** assessed: '*I would strongly recommend that Ms Michel should receive robust psychological treatment in inpatient setting in order to understand her relapse triggers and the association between the mental disorder and risk of future violence. She is clearly someone who does not respond very well to stressors and has engaged in seriously self-harming behaviours due to poor problem-solving skills'* **[§ 9.1.8, Dr B [I/S] Report, 29th April 2019].**

56. **Ms C** also raised this issue in her May 2019 report: '*Ms Michel seems to have difficulties with problem-solving and stress and these factors appear to predispose her to deteriorations in her mental health. Furthermore, it appears that Ms Michel may struggle to identify the lead up/building up of stress and does not seek help to mitigate these risks once they reach a point they seem insurmountable and result in extremes of behaviour (e.g. violence and self-harm….Ms Michel has an extensive history of self-harm and suicide attempts which could be indicative of difficulties in coping and problem-solving, especially in the context of interpersonal relationships.'* **[§6.3, Ms C [I/S] Report, 20th May 2019].**

57. In my view it was important that this information was included in risk assessments, including in the HCR-20 which is used in forensic settings. I would certainly have found it useful to have this information about Marion when she was alive, as it subsequently

made me realise that she processed information differently to other people; what other people may see as minor or easily resolvable issues, could be a big issue for her and may seem impossible for her to grapple with or talk about. From my review of the documents, I understand that there are no references in staff notes or risk profiles to Marion's difficulties with problem-solving and therefore there is no evidence that staff understood this.

Fuji Ward

58. Marion lived on two wards while she was detained at Brockfield House. I will deal with each ward separately.

Fuji Ward environment

59. Marion was treated at the Fuji Ward, a forensic medium secure female ward, between 20th December 2018 to 16th September 2021. It was described by Marion's keyworker on that ward, **[I/S]**, in her witness statement for the inquest into Marion's death, as, *'[a] 12-bedded medium secure/high needs ward where women's risk and clinical needs are comprehensively assessed and clinical interventions provided. The ward aims to provide the least restrictive options for care and a clear progressive route to community rehabilitation'* **[Page 103, Inquest Bundle 1].**

60. I visited Marion on Fuji Ward from the end of December 2018 until she was allowed unescorted ground leave and then unescorted area leave from 15th May 2021 to Wickford. There was a gap in my ward visits during 2020 and 2021 due to the COVID-19 pandemic. Marion's ability to use her leave permission was sometimes delayed by the restrictions in place because of the pandemic. Once Marion had ground leave, we would have a picnic lunch in the grounds. From then on, I did not go into the ward at all, so I can only speak about the **ward** up to this period.

61. Brockfield House was purpose built as a forensic secure unit. Due to it being a modern building, designed for this purpose, the impression I got when visiting was positive. I had no concerns about the ward environment. I was able to look round the wider building (excluding wards and offices) at carers' event which I think was held there in either 2019 or 2021. The security staff working on reception were always very welcoming and over time they got to know who I was visiting.

62. The building had a central courtyard area with wards arranged around this. There was a café that both staff and patients with permissions could visit and mix with patients that they knew from other wards. There were activity rooms, therapy rooms and offices upstairs. There was a sports hall including an outside area for sports and a small gym. Each ward had its own outside space. There were high wire fences around the whole of the ward gardens and around the perimeter. Entrance by car was via a security gate.

63. Fuji ward had bedrooms off corridors. All bedrooms were lockable. Marion had a key to her bedroom. The bedroom had an ensuite bathroom. I never went into any of Marion's bedrooms on Fuji Ward as I did not think that this was permitted for visitors. However, I was able to get a sense of the ward during my visits. There was a visiting room on the ward and if there was more than one set of visits taking place at once, then sometimes I would visit Marion in the dining room. There was a separate toilet for visitors' use both on the ward and in the reception area.

64. The main visiting room on Fuji Ward was at the end of the hall near the main entrance to the ward. It was a room with sofas and soft chairs and there were arts and crafts on the wall and posters made by the patients. There were also posters and lists saying what changes patients had asked for and what had been done as a result. I must have been shown around the ward on one of my visits as I recall being shown the communal area, garden area and a further corridor with bedrooms along it. The communal area had soft seating and a television as well as tea and coffee making facilities for patients (non-boiling water). I was aware from Marion that there was also a sensory room which the women on the ward had helped staff to set up. Women on the ward could use this space. I am not sure if this depended on staffing capacity. The staff's office was off the communal area. There was an open feeling with wide corridors, and the outside space was well used in the summer with bean bags to lounge on.

65. Initially, Marion spent the daytime in the communal area and watched TV there. I understand that this was to enable staff to assess new patients. Once staff thought that the patients were ready, they were given permission to have a TV in their bedroom, which they had to purchase themselves. My understanding from Marion was that most patients watched TV in their rooms. The exception to that may have been a special TV event, such as an awards show or a high-profile sports event. Once Marion had a TV her room she tended to stay in her room unless she was out doing an activity or having lunch in the diner.

66. I think that the ward environment on Fuji Ward did meet Marion's basic needs. She had ensuite facilities, she could have a range of her own toiletries and beauty products (these were kept in a locker for each patient) accessed by staff, there was access to sharps (such as razors) under staff supervision and provided by staff. Marion was allotted a weekly slot to do her washing and drying but there was no ironing permitted. She remained independent in these tasks. She also had a timetable of activities.

67. Marion was used to living independently and enjoyed cooking. Marion was not keen on the *'trolley food'* as she referred to it, which was the food provided by the unit for patients. She ate it but did not really enjoy it. In the evening there was a choice of sandwiches, soups and salads. I recall that there was a choice, and patients were able to pre-order what they wanted. Marion told me that she liked being able to choose, but the quality and choice varied over the time she was there.

68. Once a month, patients on Fuji ward would cook breakfast for the other patients. This was called 'Breakfast Club' and was arranged by occupational therapy. I think there was a rota for this, and one or two patients, subject to their permissions and ability, would work together to cook the meal with help from staff. Marion enjoyed this.

69. Once a month on a Saturday evening, patients could order a takeaway. EPUT contributed towards the cost – I think £5.00 - with patients paying the remaining amount. Marion was good at maths and budgeting, and it was not long before she had the role of taking the orders and gathering the money from other patients. Patients could have different takeaways if enough people wanted one kind of food to cover the delivery. Marion looked forward to this and I thought that it was a good idea.

70. I think every morning there was a meeting with staff and patients to relay any messages and hear any views. I sensed that patients were able to express their views about things and that these did appear to be followed up, at least at times. I got this impression from posters in the visiting room which had the *'You asked'* and *'We did'* format.

71. As Marion gained permission to move around certain areas of Brockfield House on her own – the café, the shop and welfare (to gain access to money and resolve any queries about her benefits and similar matters), she chose to buy a meal from the café or canteen a few times a week, as she preferred this food to the *'trolley food'*. This

was ‘taken away’ and eaten back in the ward’s dining room. This was accessible to patients who had permission to leave the ward, and staff.

72. In the wider building, Marion had some access to a gym, which she used when she could get a slot. She had access to a sports hall too. She also did other sports. Marion achieved ground leave permission on 4th January 2019 for 15 minutes twice a week and then up to four times a week. All of these were on an escorted basis was their going ahead was dependent on staff availability. Eventually Marion was granted unescorted grounds leave and she was able to walk around the grounds inside the perimeter fence, which she did when the weather permitted, and she felt like it. After a while there were also a few bikes available to cycle round the grounds.

73. Marion was usually keen to engage in the programme of activities as it got her off the ward and made her days go quicker. She also knew that engaging meant that she was showing that she was progressing towards discharge. At the weekend sometimes there was bingo or karaoke in the evening, but I do not think that Marion attended these as much preferring to watch TV in her room.

74. A library service van visited the unit, parking outside in the car park on a regular basis – fortnightly or monthly (until the pandemic). Once Marion had ground leave, she visited the library on a regular basis and really enjoyed reading.

75. Initially, in order to contact Marion, I had to call her on the ward phone which was a payphone in the communal area. However, at some point either in 2019 or 2020, each patient was issued with a mobile telephone that they could use to receive calls and texts. I do not remember if this was in response to the pandemic or if this change came before the pandemic. This much improved communication, especially during the pandemic when family and friends could not visit. I generally called Marion two to three times a week on regular days and would also text her occasionally.

76. After some time, Marion was able to have a Skype call with myself and our parents once a fortnight and sometimes once a week on weekends. This was dependent on a staff member being available to accompany her off the ward to the computer rooms. This was positive for my parents as they could not visit Marion regularly like I did. This was invaluable during the pandemic. I believe there was another video calling system in use on tablets on the ward after a while. I was not told about this. If the Skype call

got cancelled due to staff shortages, then I would do a telephone call with my parents and just phone Marion in on speaker phone so she could be involved that way.

77. I generally visited once a fortnight when I was able to, initially on the ward, then on grounds, and then on trips out when she progressed to having leave. The length of these visits gradually increased from an hour to start with to up to eight hours when we had a trip out. When my parents visited Marion on two trips in 2019, additional time was allowed in recognition that they had come a distance to visit her, so there was some flexibility, but this had to be agreed.

Safety on Fuji Ward

78. From what Marion told me during my visits and during telephone calls she did not always feel completely safe on the ward. This was the nature of the assessment ward. Women would be transferred from prison who would be acutely unwell at times and other patients would also relapse at times. Marion understood that they were unwell and she learned to make herself scarce when she sensed or saw an incident could be starting – at times certain patients had an antipathy towards each other and there could be regular clashes.

79. I recall Marion telling me about a time when a knife had gone missing after lunch, one absconding incident on leave, a few assaults on staff or other patients, or self-harming incidents during her time there. Marion understood that the women involved were unwell and she tried to stay safe. I understand that Marion was involved with such an incident on one occasion and was not hurt. I believe from what Marion told me that staff did take these incidents seriously and there were several DATIX incident reports released by EPUT as part of the inquest process, which backed this up.

80. Marion had monthly searches of her room throughout her time at Brockfield House. I was never made aware that anything of concern had been found in her possession. I was never informed of any of the DATIX report incidents in this respect.

81. Marion could ask at ward rounds to be allowed to have certain items as time went on, such as shoelaces, CDs or DVDs in her room, and access to razors and similar items. When it was assessed that she could have such items (sharps were always supervised on Fuji Ward) her requests were granted. Marion herself probably felt restricted – the lack of shoelaces did seem to go on for a while and not being able to

have a bath. However, for us as her relatives hearing this feedback from Marion, it seemed to indicate that safety and risks were being monitored. Marion had to ask to order DVDs to watch and I think this was during Covid when there were more restrictions. I remember one concerning event in relation to this which Marion told me about, that she was allowed to order a DVD of 'Killing Eve' (a series about a psychopath who attacks people with knives). Marion advised me that **Dr B** told her that he would not allow some patients to watch this, but it was okay for her to. I found this strange given Marion's history and also that her first assault of her partner took place after watching a violent DVD.

82. Having said this, during the inquest it is my recollection that when the Counsel for Essex was asked to look back over MDT notes to identify the process for Marion to have access to sharps and other items and the decision-making process behind this, it came to light that Marion had been allowed several items by MDT prior to the original decision making as to when she could have these. No reason for these items being provided several months earlier was given in the MDT minutes, therefore I do have concerns about decision-making or the recording of such decisions and the rationale for those decisions. These were important issues, but no rationale was given in her specific case. The premature ending of psychology 1:1 sessions due to lack of a psychologist for Fuji Ward, also meant that these risks were not further explored.

<u>Staffing arrangements, training and support on Fuji Ward</u>

83. Staff numbers had an impact on Marion. At times there would be several patients in need of staff observations, sometimes 2:1 and other times 1:1. I recall Marion telling me once that there were 3 patients on such observations taking up four of the six staff. The knock-on effect on the remaining patients was that the ward could be short-staffed with far fewer staff who were available to respond to patients' requests, escorting them to groups and taking patients on escorted leave so they could progress to more independence. I do not know much about the staffing levels then but was aware from what Marion said that there was a fair turnover of staff and agency staff were routinely used. When there were more challenging and aggressive patients on the ward, this was clearly hard for staff too and anecdotally there seemed to be more sickness absence at this time. At one time Marion told me that some agency staff refused to work on the ward.

84. I recall that Marion was asked to move rooms on a few occasions. This was usually due to the needs of other patients or to break patients up. I believe that due to Marion being generally compliant, staff probably approached her more to move as they knew she would understand the reasons behind it and not cause a fuss about it. Sometimes she moved to rooms she liked better and sometimes she did not like her new room. On one occasion, quite late on in her time on the ward, she moved back to the assessment corridor to help staff break up two patients who did not get on. Sometimes I felt that Marion's nature was taken advantage of to make it easier for staff to manage things.

85. Marion's keyworkers changed a few times during her time on Fuji Ward. She got on better with some. Students would often be sent to talk to her. Marion's keyworker for most of the time was helpful and Marion got on well with her. She was a good advocate for Marion and raised issues on her behalf in ward round – such as when Marion was frustrated by the new psychologist taking a lot of time to get to know her.

86. Marion did not experience any significant changes on Fuji Ward. She moved rooms and experienced some frustration and disappointment about cancelled activities sometimes, but the activities often took place. During Covid there were more restrictions but life on the ward carried on as activities on ward continued and Marion did not have area leave for some of this period so was not used to going out anyway.

87. Marion was able to advocate for herself most of the time. Her keyworker went through her rights under the Mental Health Act at regular intervals and this was recorded.

<u>Socialising on Fuji Ward</u>

88. Through attending different groups and being on the ward, Marion made friends. She had one friend, initially Patient M, and later, Patient C and Patient T. Marion got into watching Eastenders and I believe they would all watch it in their rooms and then discuss the episodes afterwards. These friendships were very important to Marion, as she had struggled to make friendships throughout her life and had often felt lonely.

89. Marion told me that she would also give advice to other patients who were struggling. She told me that she encouraged them and praised them for doing well and making progress. I had a chance to meet some of these patients at a memorial service held

at Brockfield House for Marion. It was good to hear from them that they had appreciated Marion's support and encouragement.

90. When Marion was not having psychological 1:1 sessions, due to there being no ward psychologist in post (a gap of 11 months), it was suggested at a ward round that Marion work with an occupational therapist to develop a short course on DBT that was accessible to women who did not want to attend the formal DBT groups on offer or who may struggle to do so. This was partly to assist Marion to continue to show progress in her understanding of DBT model, but it was also meaningful to Marion. She told me that her and the occupational therapist had to encourage a few women on Fuji Ward to attend, however the sessions did take place and Marion certainly gained from this. Marion already had a rapport with some of these patients.

91. As Marion progressed, she was able to cook a meal once a week with an occupational therapy staff member present. Marion would choose a recipe, and the occupational therapist would buy the ingredients, and Marion would cook in the Fuji Ward kitchen. As outlined below, Marion underwent a 'Sharps Assessment' on 7th June 2019 before self-catering. Once Marion had area leave, she was able to buy the ingredients herself and be supervised by a ward staff member I believe. Marion had access to outside space as each ward had a garden area laid to lawn with a few plants. Marion loved sunbathing and would prefer to do this on hot days than attend activities. Once Marion got ground leave, she was also able to walk around the perimeter of the building. I also joined her in this on some of my visits. Prior to leaving Fuji Ward, Marion also got area leave and this meant that she could get the bus into Wickford and do some shopping and have lunch out. She usually got the bus and sometimes a taxi back. Marion enjoyed this and was able eventually to join a gym in Wickford where she would go swimming with another patient who she was friends with, and then they would have lunch before returning.

92. Marion's main **complaints** were about the quality of the food and shortage of staff curtailing activities or leave. Occasionally, there was a staff member that she did not like, but overall, she understood the restrictions and freedoms of the ward. Sometimes she got bored, but she engaged in different activities and she enjoyed the book club.

93. As for Marion's dignity and privacy on the ward, Marion was on full observation when she arrived, and this included being observed in the shower and toilet area of her room. She understood the reason for this and although she did not like it, she never

raised an issue about staff being over intrusive. Gradually these observations were reduced, and by February 2019, she was on general observations. Patients had the keys to their room and once they were assessed as being able to manage it could go into their rooms as they wished. In their rooms would be the items that they were allowed to safely have, this being decided at fortnightly ward rounds. Marion's bedding and towels were all provided by the unit. It was my understanding that she was not allowed to have her own I assumed due to health and safety.

Transfer to Aurora Ward

94. Marion moved to Aurora ward on 16th September 2021 and she remained there until the day that she sadly died there on 4th March 2022. Marion transferred here after about two weeks of daily visits to the ward. Marion told me that **Dr B** had told her that this was slightly longer than the usual schedule of visits to the new ward, due to her history. When Marion told me this, I felt reassured that the impact of change on Marion was being borne in mind by **Dr B** This transfer was part of Marion's original care plan and had been agreed by the Ministry of Justice and the Jersey Authorities.

95. Aurora ward was a ward used to prepare and assess patients for discharge. My understanding is that most of the patients had daily leave into the community, may have had volunteer jobs, and were expected to cater for themselves in terms of food and cleaning their rooms. I was pleased that Marion was finally making clear progress towards a discharge, which she presented as happy and excited about. Fuji Ward had become quite restrictive for her due to the needs of other patients. Marion was also pleased to be sharing a flat within Aurora Ward with her two friends, Patient T and Patient C.

96. I did not have any concerns about this transfer at the time, but after her death I found out through the PSII report that there were inadequate risk assessments and practices in place for sharps use on this ward, and indeed in Brockfield House as a whole, which I will get into below under the section 'Events of 4 March 2022'.

97. There was no oversight of the transfer process or the procedures of the new ward by the Jersey authorities – Marion did not seem to have an allocated worker at this time, and I understand that no one had been attending CPA meetings for some time. This was also a gap, as there was no due diligence by the placing authority, who could

have asked questions about such things as what risk assessments were in place, given the greater freedoms of this ward and Marion's known risks.

98. I do not recall receiving any specific information from any staff member about the transfer. All the information that I got about the transfer was from Marion, in terms of information about her introductory visits to the new ward, how long the process would take, the facilities on the new ward and general expectations.

99. With hindsight I believe that I should have been offered more information about Marion's transfer to Aurora ward and asked if I wanted to look round. As part of the inquest proceedings, the 'Protocol for Inter ward transfers within the Secure Services SSOP4' was provided, and at Section 4.6 it notes: '*When collecting information, it is important that as much detail as possible is obtained about the patient from his /her relatives or carers as well as the patient'.* Section 6.3 goes on to say: '*Unless there are good reasons to do otherwise, relatives, relevant carers of the patient will be informed of any transfer provided the patient consents to this disclosure.'*

Aurora Ward environment

100. I never visited this ward while Marion was alive as by the time she moved to this ward, we always went out in the community. I was never offered to visit the ward or speak to staff who worked there although I understand from the evidence gathered for the inquest that I should have been offered this.

101. I only visited the ward after Marion had died when I went to collect her possessions. The ward was purpose-built, and was at the front of Brockfield House. It comprised of flats for one, two or three people off a main corridor. During her time on Aurora ward, I believe Marion only moved flats once, when Patient T moved out, she was moved to a two bedroom with Patient C, rather than a three bedroom flat.

102. Marion was the sole occupant of a flat for two people when she died. Her bedroom looked over fields and was spacious. There was a separate toilet and bathroom as well as a kitchen and lounge which were all shared, but I did not go in those rooms.

103. There was a communal area which was the area outside the flats. The door to the staff's office was opposite the door to Marion's flat. There was some outside space

- a terrace area – this was not a garden, as the ward was on the first floor, but it was open to the air. Marion had access to the community when on this ward and therefore this was not such an issue. Marion never raised any issues with me about the ward environment.

104. Marion would be woken up, if not already awake and expected to clean and mop the flat and her room. Marion would attend the morning meeting – at which I believe patients were reminded or told about appointments that day and any housekeeping issues. During the national COVID-19 lockdowns I believe that the patients were informed about any decisions that were being made in respect of the lockdown or meetings to consider whether these would end. I think this was also an opportunity for patients to raise any issues they had.

105. Marion would then do whatever activities she had planned. A couple of times a week she would go into Wickford for food shopping. She would also go into Wickford to go the gym for a swim, usually with her flat mate, at least once a week. Marion also went to a Pilates class. She was allowed to go to Wickford up to four times a week. Some of these activities depended on people being able to book in time and Marion would ring up early to try and get a place each week when the booking opened. I believe that there were certain rules such as if you went into the community to do an activity such as the gym, then you could not also do shopping.

106. Marion also continued to do some activities at Brockfield House which were mainly educational courses. Occasionally, Marion would go on an outing arranged by the occupational therapists with women from Fuji Ward. I understand that there were no arranged activities on Aurora Ward.

107. I cannot comment on the privacy and dignity of patients as I never visited Aurora ward. Marion never mentioned any issues of concern to me.

<u>Staffing arrangements, training and support on Aurora Ward</u>

108. I never had any contact with anyone from Aurora ward. I had no link whatsoever to the ward, including no contact names or details. It was upon Marion to tell me everything relating to her treatment and care on the ward.

109. I did not ever meet any of the nurses or staff on Aurora ward until after Marion died. Marion told me that she did not really get on with her keyworker, who I think she said worked mainly nights, I think they just did not have a rapport. It was clear to me from the Aurora ward keyworker's evidence at the inquest that she did not know Marion well. It appears that Marion's keyworker at this stage had not asked Marion much about herself and found out what was important to her nor picked this up through working on the ward. The nature of the ward meant that with patients being out a lot combined with staff shifts, there was probably less opportunity to get to know each other than on Fuji Ward.

110. Although Aurora Ward was encouraging and supporting the independence of patients, it is noted that discharge is a risky time and therefore I believe a more meaningful keyworker relationship could have helped Marion, as she had confided in her last keyworker on Fuji ward when she was feeling unsettled by new information.

111. In the statement of Marion's keyworker on Aurora Ward, which was provided for the inquest, she said that there were usually three staff on duty, two unqualified support worker staff and one mental health nurse. This may have been when the ward had 12 patients **[Page 42, Inquest Bundle].** At the time Marion died, EPUT have stated that there were nine patients on the ward.

Treatment, care management and plans

112. The responsible clinician for Marion at EPUT's Brockfield House was **Dr B** a consultant forensic psychiatrist. His reports to the court in Jersey were detailed and extensive and it appears from reading them that he had a very good understanding of Marion's mental health history, risk factors and a plan of how Marion could be treated at Brockfield House.

113. **Dr B's** view was that Marion could be treated at Brockfield House, and most of the treatment had a psychological focus (DBT and psychoeducation), and offending behaviour work and engaging with activities provided by the occupational therapy team including education [**Dr B** Report, 29th April 2019, §9.1.12].

114. **Ms C** the forensic senior psychologist's assessment was also thorough, and I believe that she got to know Marion well. **She** advised in her

Psychology Assessment of 20th May 2019 that the plan for Marion's psychological treatment was to include a range of group work, skills based work, understanding mental health and risks, DBT, emotional regulation skills, distress tolerance skills, and psychoeducation groups, social skills, individual intervention with CBT, offending behaviour work, and to complete and update an HCR-20 every six months or more if clinically indicated. She also noted a risk management plan to co-develop a relapse prevention plan and to engage with occupational therapy.

115. Marion advised me that she had EUPD traits and sent me an information sheet about it. I did not know the full details of how this applied to Marion until after her death reading the reports that were released.

Paranoid schizophrenia

116. Marion remained on the same psychiatric medication that she had been on for some years. The medication was seen as working and not needing any adjustments. I believe this remained the same throughout her time at Brockfield.

117. For example, I understand that EPUT's medical records show at pages 391 and 406, that on 13 February 2022 and 28 February 2022 respectively, it was noted that Marion was on the following medication plan: Amisulrpide Tab 600mg OD; Losaratan Tab 50mg OD; Venlaflaxine-XL Cap 150 mg OD; Indapamide Tab 10mg OD; Colecaolciferol Caps 400units OD; and Cetirizine Tab 10mg OD.

118. Medication was the main treatment for this condition, but Marion also attended the 'Unusual Experiences' group and 'How to Talk to Anyone', a social skills group as well as other Occupational Therapy groups.

EUPD traits

119. The main treatment for EUPD for Marion was DBT.

120. **[I/S]** was the Lead for DBT at Brockfield House when Marion was there. In her statement for the inquest, she describes the programme offered at the unit: '*The DBT Programme consists of four modes of treatment: DBT Skills Group; DBT Individual; DBT Coaching; and DBT Consultation Team. The phases of treatment are skills acquisition, skills strengthening and skills generalisation. … DBT Skills*

Group: This treatment mode is a teaching group where a group of patients are taught DBT Skills (skills acquisition phase). The group is ongoing (and has run continuously since its inception at the old Runwell Hospital site). The content cycles through four modules – Distress Tolerance; Emotion Regulation; Interpersonal Effectiveness; and Mindfulness. The Mindfulness module is delivered in two sessions at the start of the other modules, and a mindfulness exercise is done at the start of each skills group. In pure DBT the cycle (completing all four modules) is done in 6 months, with the expectation that a participant attends two cycles.' **[Page 66 – 68, Inquest Bundle 1].**

121. Marion chose to attend the group DBT sessions on a regular basis, starting in July 2019. Patients were put forward for the groups, but it was their choice to attend. I understand that Marion completed all the modules for the first time by March 2020 and then repeated them all again by February 2022. Marion had asked to take part in the course for a third time while she was waiting to be discharged and was due to start this after the ward lockdown in March 2022. There were natural breaks between modules usually of a few weeks. Regular homework is set, and patients can be supported to complete this if they wish. Marion usually completed this on her own.

122. One aspect of the DBT that I understand did not happen consistently throughout Marion's time at Brockfield House, was the weekly 1:1 session (DBT Individual) with the ward psychologist. These happened from July 2019 to September 2020. Once the original senior forensic psychologist, **Ms C**, left in September 2020, no one was appointed to her role for some time and during this time, Marion did not have this individual work. Marion was frustrated about this. It was during this period that Marion was asked to put together a series of short sessions of simplified DBT techniques for those patients who chose not to attend the DBT sessions.

123. Eventually a locum forensic psychologist, **Mr D** started in May 2021 and Marion started sessions with him. In his statement for the inquest, he said that the work that he had been asked to do with Marion from May 2021 onwards was to assess if there were any unmet treatment needs and to complete the Relapse Prevention Plan. **He** stated: *'Two unmet treatment needs noted by me, in the psychological assessment completed by* **Ms C** *(sic), indicated 1:1 psychoeducation work around psychosis and personality traits 1:1 work around her Index offence.'*

124. From my review, I can only see that there were six general sessions with the psychologist once he started. During these sessions, Marion raised the issue of self-

forgiveness for attacking her ex-partner which led to the decision by the psychologist to focus on some self-directed work with Marion filling in worksheets from a booklet on this topic. This work started when she moved to Aurora ward in September 2021 and was almost finished at the time of her death. While I think it was important to Marion to do that work, it meant that there was no focus on discharge and the Relapse Prevention Plan by the psychologist in his work with Marion at a time when there was active planning for discharge.

125. Given that this work was self-directed as it being completed by Marion, I cannot understand why **Mr D** could not use the time he would have spent with Marion to start completing the Relapse Prevention Plan which originally had a timescale of completing by February 2021. At the time of her death Marion had not seen **Mr D** since December 2021 and the Relapse Prevention Plan remained outstanding.

126. I was not aware of any changes to Marion's diagnosis while she was alive. I am aware tha **Ms C** the first psychologist that worked with Marion, had noted that she was concerned that Marion may be learning DBT by rote. This was not the general view and after Marion had continued the programme.

127. Another element of treatment was the occupational therapy service led activities. This is explained by the occupational therapist, **Ms E** in her statement for the inquest dated 16th September 2022: 'There is a therapeutic timetable on the ward that is co-designed by the Occupational Therapist and the Activity Co-ordinator. This timetable contains a variety of sessions *which allow an opportunity for the OT to assess a patient's level of functioning and provided meaningful activity and engagement in a variety of self-care, creative, leisure and educational tasks. A number of activities take place on the ward environment, and some take place off the ward including gym and the education rooms, however off ward groups will often only be accessed once settled.'* **[Page 127, Inquest Bundle 1].**

128. I had no concerns about decisions made about treatment or medication. There was a clear pathway for the administration of medication at Brockfield House, starting with staff administering it progressing following time and assessment to Marion going to the nurse station to ask for her medication and being witnessed taking it to having a week's worth of her medication in her room and being fully responsible for taking it on Aurora ward. Marion understood this process. Marion had been **compliant** with her medication for many years.

129. I think it could have been improved if she had had 1:1 sessions with a psychologist throughout her time at Brockfield as I think this may have helped address and check out in a more detailed way whether Marion did have not just an understanding of DBT approaches to her mental health, but that she was also able to put them into action in stressful situations. As far as I am aware the vacant post was out for recruitment during this period.

130. I take this opportunity to note below some of the DBT sessions Marion was noted to have had in the weeks leading up to her death:

	ACTUAL APPOINTMENTS	EPUT RECORDS
13 Jan 2022	*She then left the ward for DBT sessions but the session was cancelled*	p. 83
20 Jan 2022	*Marion attended DBT today*	p. 102
27 Jan 2022	*Marion attended DBT*	p. 117
1 Feb 2022	*[Ward round]* *.. Psychologist: apologised not to be able to meet up with Marion this morning but promised to get in touch with her later.*	p. 163
3 Feb 2022	*Marion attended DBT today*	p. 169
10 Feb 2022	*Marion attended the DBT group*	p. 235

Lack of understanding of Marion's profile

131. On reading through the bundle prior to the inquest in 2023, I noticed discrepancies between what was understood about Marion's risk profile. There was some initial disagreement between **Dr B** and **Ms C** regarding whether Marion was psychotic at the time of her index offence in 2018 or not. They agreed that she was psychotic in the attack in 1999, but **Ms C's** opinion was that she was also psychotic in the 2018 assault, while **Dr B** was that this was related to the traits of EUPD. In the end **Ms C**, the psychologist, conceded to **Dr B's** opinion.

132. It was important for the clinicians to understand the nature of Marion's sudden and severe onset symptoms, which the experts commented on in their reports for the court. However, it appears that Dr B did not correct the psychologist's or nurses' mistaken understanding or recording of the nature of Marion's episodes; and instead there was a perception that her most recent assault was caused by psychosis. For example, Mr D would refer the last index offence being preceded by a psychotic breakdown. There is no evidence that Mr D's mistaken understanding was ever corrected.

133. I believe that staff would have still had access to Ms C's psychology report of May 2019 in which she gives the view about psychosis. I understand that parts of such reports were routinely copied and pasted by staff. New staff also wrote about this which suggests that once something is written by one staff member, unless someone who knows it is wrong and corrects it, this confusion continues. I believe there is evidence that this led to confusion amongst the staff which continued in the reports and statements prepared after her death.

134. I am concerned about communication amongst the MDT. This raises questions for me about whether other professionals in MDT felt able to challenge Dr B I do not know why these 'details' did not seem to be important to MDT. I strongly believe that these erroneous references in care plans and risk assessments and other reports is likely to have impacted the staff's understanding of what signs to look for if Marion became unwell. Staff would have been looking for psychotic symptoms in Marion because of this error being left unexplained and uncorrected. It may also have impacted on Marion's own understanding of her mental health and past harmful actions, as staff treating her were not clear about this.

Engagement of Marion and her family

135. Marion was involved in the plans for her care. When she arrived at Brockfield House she knew she was there for a 12-week assessment. Once this was over, she knew that she would remain there until the end of the court proceedings. She knew that the proposal was for her to remain there for treatment for the duration of the Order and at the outset that this was to be about two to two and a half years according to [I/S] Dr B

136. It is my understanding that the care plan was informally reviewed every two weeks at Ward Round which involved all those professionals involved in her care. Marion also attended this and could ask for changes or things she wanted put in place or make comments about her care plan. She was supported by her keyworker on the ward with this.

137. When there was no psychologist in place on her ward, she regularly asked about whether there had been an appointment as she knew that this work was needed to progress her care plan. She was also able to check whether professionals in the group had completed tasks which had been set at previous meetings. Decisions would then be made at ward round, and any leave requests would be drawn up to be signed off by Dr B or his colleague after the meeting.

138. However, due to the nature of her detention by Hospital Order, any decisions or proposals by her clinicians about her care plan had to be authorised by both the Ministry of Justice and the Jersey authorities. The Ministry of Justice decisions were overall timely however the follow-up decisions by the Jersey authorities often dragged on, sometimes for months, which was frustrating for Marion.

139. There was also a more formal six monthly meeting – a Care Programme Approach (CPA) or Section 117 meeting. These were attended by Marion's MDT and each professional presented a report covering progress and any issues in the last six months. I was invited to attend these meetings. I think I attended a few times in person and then attended virtually during and after the pandemic. Marion and I were able to hear the comments of other professionals.

140. I was also able to give my views or reflections at these meetings of how I thought Marion was from my visits and any issues from the rest of her family. On one occasion I could not attend the CPA and had written something to be shared at the meeting. When I received the minutes afterwards, I could not tell if this had been read out or shared.

141. I had been able to talk to the original psychologist, Ms C at length about what I knew of Marion's history. I had also contacted her when I was on one occasion worried about Marion. I never had any contact from the locum psychologist who was working with Marion from May 2021 onwards. I was not so involved and never met

staff once Marion transferred to Aurora ward. I would have attended the CPAs virtually and I do not know if the locum psychologist was there. I never had any private conversation with him.

142. There was never a direct link with Marion's keyworkers, which I think would have been helpful. The only person I ever spoke to about Marion's history was the original forensic psychologist, who left in September 2020. This meant that I had to assume that staff had all the information about Marion as I was not given the opportunity to speak to staff on the wards that Marion lived on (outside the CPA meeting format). With hindsight I think this would have been helpful. Also to have the new keyworker and new psychologist contact me when they took over to introduce themselves and to check if there was anything I wanted to ask or tell them.

143. I do not think that Marion was given enough information and support around her discharge planning. In her evidence at the inquest, the social worker explained that detailed information about accommodation and discharges were not given for a reason; to try to prevent patients getting set on one accommodation option that may in the end not be available for them. The social worker explained that the issues that could impact on whether a patient was agreed for a particular resource were complex, including funding issues and rules of placing authorities, availability and suitability of places for individual patients and the intersection of this with timescales for discharge. I understand this, but I think more could have been done to show Marion or explain to her and support her with the assessment meeting. Finding accommodation for anyone whether it be renting or buying involves having a lot of information and then some options falling through and others working out. Not having any information seemed to be seen as better for patients.

144. I do not consider that I was involved in discharge planning at all. I had spoken to Marion at some point about coming to live nearer me rather than return to Jersey where I felt she would be isolated and have a limited network and support. Marion seemed keen for this, and this then became the plan. I was not offered any time to discuss this with anyone – it just became the plan. I was committed to it, but I also had some concerns about how I would manage supporting Marion, my own family, working in a stressful job and supporting my parents in Jersey.

145. It was only after Marion's death that I had access to some of EPUT's policy and procedures. These made me realise that I should have been more involved in assessments of Marion, ward transfers and discharge planning – see for example **CLP28 v.3 Clinical risk Assessment and Safety Management Policy, implemented 1st July 2017.**

146. I also have concerns that there was little to no oversight by a named worker from Jersey, for most of Marion's time at Brockfield. As far as I am aware no one from the Jersey mental health team ever spoke to Marion on her own prior to the CPA meeting. When they did come, they just attended the meeting but did not engage with Marion individually.

Concerns and complaints

147. I do not recall being given this information about how to complain as a carer specifically. I was provided with some written information about Brockfield House in January 2019, this included a 'Patient Information' booklet. This provided information about how a patient could complain to the 'Patient Experience Team' but not a carer. There was also information about a carer self-assessment. I did not raise any concerns or complaints during Marion's admission. I am not aware of Marion making any complaints.

Safety on Aurora Ward

148. All visitors to the unit and patients returning from ground or area leave had their bags searched and went through a scanner. However, during Marion's time there Marion told me that at least one man had died of a drug overdose on one of the wards, but I think it may have been two.

149. Marion was placed under full 24 observation by one staff member when she first arrived on Fuji Ward in December 2018. I believe this is called Level 3 observation. She was also not allowed certain items such as shoelaces and any sharps including DVDs initially. I cannot remember how long Marion was under observation for, but I think it was about a week or so, then this reduced sometime in the New Year to Level 2 observations, which was four times in an hour. On 19th February 2019, Marion's observation level was reduced again to Level 1 general observations – at least once an hour. Dr B advised that this decision was made in consultation with ward staff

and other MDT members during a ward round. Marion did not like being observed but she understood why it was in place (due to her previous self-harming incident at transfer). She did not raise any issues about the nature of the observation with me.

150. I did not have any particular concerns about restrictive practices on Aurora Ward. Marion knew the system by then and what she was allowed in her room. As far as I am aware Marion was never restrained by staff at Brockfield House. Her behaviour never gave staff the need to do this.

Leave on Aurora Ward

151. One of the leave options was Ground Leave, which enabled patients to leave the unit and walk around within the perimeter fence. There was a gate which allowed access to visitors which reception could open so any leave had to consider that a patient may be able to leave through the gate on ground leave. There was also Area Leave – initially this would be to Wickford only. After a while, patients could request to go to different places, such as Chelmsford or further afield depending on the request. Such leave could be on their own, with another patient if agreed or with a friend or family member. Another form of leave was Home Leave – I am unsure if this is part of Area Leave or a separate category. For some patients they would be allowed to visit family members in their homes and these could be supervised or unsupervised. Finally, there was Staying Home Leave – patients nearing discharge who had a home to go to, could be granted leave to have overnight stays and spend a period at home. There must also have been specific leave to attend hospital, dental and GP appointments as necessary. These were usually always accompanied and supervised by a staff member.

152. Marion moved through the various leave stages and was on unescorted Area Leave when she died. Marion had to wait a long time for the decision to come through from the Jersey authorities for Area Leave and no reason was given for this. The Ministry of Justice decisions seemed to be much timelier. Marion was granted Area Leave while she was still on Fuji Ward, however due to the pandemic, she was not able to use this. Marion would have to show a 'Section' form signed by **Dr B**, to security staff at reception before she left the building.

153. Before community leave took place, the senior occupational therapist undertook an assessment with Marion, checking things like safety when crossing roads, use of money and social abilities.

154. Fully unescorted Area Leave to Wickford was granted on 15th May 2021, and Marion was also granted 2 extra hours to attend a local swimming baths in Wickford. I did not have any concerns about Marion's requests for leave and both Marion and I understood how they fitted in with the progress of her care plan. It was a gradual progress and could move forward and back and forward again if there were any issues during the leave.

155. Marion's various types of leave were managed well and were appropriate to her stages of progress through the system. Marion was the person who told me most about the leave, what she had asked for and what had been granted. I do not recall ever being contacted prior to the period of leave to be advised of any issues to look out for.

156. Generally, the periods of leave went well and were beneficial for Marion. Marion had lived independently for most of her life and enjoyed her freedom, including cooking her own meals and shopping, having a coffee and so on. These periods of leave allowed her to choose her own food, buy the things that she wanted and experience the world and get to know the area. It also allowed her to access local facilities such as gym and swimming pool and the library. It gave Marion a glimpse of what her life had been and could be again in the future. Marion and I enjoyed many day trips to various nearby Essex towns and Christmas shopping.

157. I was able to contact staff while we were on leave but I was not given an exact contact for this. The person I spoke to most was usually Marion's social worker who was the main liaison with the family. Patients always collected their mobile phone on leaving the unit and going on leave. This was a different phone to the one that used to speak to friends and family on the ward.

158. Marion never tried to abscond and always returned after agreed leave. There was a process to account for situations where the patient was unexpectedly running late for the time of their return.

159. I take this opportunity to highlight notes of searches being conducted after leave:

DATE	EVENT	EPUT MEDICAL RECORDS
31 Jan 2022	Bag searched and personal searched when arriving back from area leave	p. 504
24 Feb 2022	Full body and room search conducted for contraband	p. 510

Events leading up to Marion's death on 4 March 2022

160. In my view, Marion was impacted by a number of changes leading up to her death. I believe that they had a cumulative effect on her and raised her stress levels to an extent that led to her seriously self-harming and in doing so accidentally killing herself. This was even expressed by the PSII, at Page 39: *'Several changes were taking place in the weeks leading up to the incident; Marion's flatmate moving to a separate flat, DBT sessions ending, the court appearance scheduled for 4th March was postponed to the end of the month. There was no indication that Marion's mental state or behaviour changed during those weeks, with the exception of the last homework she completed for the DBT, which was handed by her on a scrap piece of paper. This was out of character and staff noted it with a follow-up meeting arranged for the 8th March 2022.'*

<u>Routine</u>

161. Before outlining the key changes and events in the lead up to Marion's death, it is important to note that Marion was very fixed in her routine and her mental health would be impacted by changes to her routine. It is important to bear this in mind when considering the changes that took place in the lead up to her death, and the lack of appreciation for how they would impact her.

162. Dr B noted at **Paragraph 4.2 of his progress report of 13th September 2021** that, *'it was noted that Ms Michel was very regimented in her routine and did not like it when her routine was changed'.* In his statement to the coroner, the second forensic psychologist, Mr D notes that he was asked on 4th August 2021 to speak to Marion as nursing staff and the occupational therapist had raised concerns that Marion could *'present as abrupt and inflexible in altering her scheduled activities when staff may have needed to ask her on occasion'* **[Page 112, Inquest Bundle 1].**

163. Dr B had expressed a similar point in his report dated 20th May 2019, when he said that *'Ms Michel has also identified that she is quick to relapse when she is stressed … in addition to change in her sleep and routine resulting in her relapse'* **[p. 128, Inquest Bundle 3].**

164. The PSII summarised at Page 39 that: '*Routine was extremely important to Marion, and it had been identified that changes to the routine caused Marion anxiety and it had been a precursor to her rapid and unpredictable onset of psychosis which led to her self-harm and the index offence in the past.'*

165. I feel that the staff should have appreciated the risk to Marion when her routine was dramatically changed. I do not think that they did. In fact, as noted above, Dr B referred to her as a 'model' patient. I believe this, alongside the lack of risk assessments in this specific area, did not help staff to be aware of the risks that Marion may pose to herself or others. The use of this term I believe contributed to a sense that Marion was not a patient that staff needed to overly worry about as she had never done anything untoward since being at Brockfield House.

<u>Lockdown routine</u>

166. Aurora Ward went on lockdown because of the COVID-19 pandemic. I understand that the PSII notes that the dates of the lockdowns in Aurora Ward were between 24th December 2020 and 25th January 2021, and then 14th February 2022 until 16th March 2022 **[Page 39, PSII].** At the inquest into Marion's death, the evidence of the Deputy Sister, Ms F was that at the relevant time, she had information that the lockdown at Aurora Ward was due to end on 4th March 2022. I note here that the discrepancy between the understanding of EPUT's Deputy Sister and the investigators' of Aurora Ward's lockdown dates show that an accurate and

definitive record of these dates was not kept by EPUT, and casts doubt on the reliability and thoroughness of the investigation.

167. I think at some point, possibly when Marion was still on Fuji Ward, we were sent some forms through the post to ask us for our opinions on what the ward could do better to give us information. I suggested that they should e-mail families a newsletter of updates and to have meetings. I think it was around June 2021 when these suggestions were set up. However, the staff never discussed the lockdown procedures and Marion's care plans in light of the lockdowns with me. All of the information that I got about the lockdowns came from Marion.

168. As I highlighted in my statement for the inquest, I spoke to Marion on the telephone throughout this post-Christmas lockdown. She carried on with her usual routine and read books and magazines and listened to the radio. She missed going out but was aware that COVID-19 figures were high again. Marion had told me that due to high COVID-19 figures in the New Year 2022, she had not been going out as much as she usually would have done and she was just doing her essential weekly shopping and going to Pilates. Previously she had usually gone out five to seven days a week, so this was a major change to her daily routine.

169. As a result of the lockdowns, I had been unable to visit Marion as much as usual due to either ward lockdowns at Brockfield House or COVID-19 in my family. I had last seen Marion on 23rd January 2022 and was due to see her again on 7th March 2022. This last visit had been rearranged several times due to COVID-19 issues. Marion was also unable to access Skype as it meant leaving the ward, but she did join my calls to my parents via her mobile phone (voice only).

170. The lifting of the ward lockdown on Aurora ward which had started on 14th February 2022, seemed to be eternally imminent. Marion told me on several occasions during the 16 days of the lockdown, that the lockdown was expected to end. I believe that she was given this message by staff on several occasions. I asked her if I should send a parcel of treats and magazines, but she said not to bother, since lockdown was ending.

171. The last occasion that she had told me that lockdown was expecting to end was on Wednesday 2nd March, when she told me that it would end on Thursday 3rd March 2022. Then when I phoned to check that evening, she told me it had not ended.

I think this constant raising of hopes was not helpful for Marion. In my view given that this was two years into the pandemic, there should have been a clear way for communicating to patients what the situation was. Marion told me during this telephone call that she was fed up of reading and had just been lying on her bed doing nothing but listening to the radio for the last few days. This did worry me a bit as this was unusual for her and I worried about her living in her head or over-thinking, but I rationalised that I would be seeing Marion on Monday and that as soon as lockdown was lifted Marion would be out to Wickford to get some shopping and everything would go back to normal.

172. Another important point to note about Marion is that she loved food shopping and preparing her own meals. But her mealtimes and access to food changed with the lockdowns. I recall that Marion had last gone food shopping on 8th February 2022 and this would have covered her for four to five days.

173. Marion told me that during this lockdown when patient's own food started to run out, staff did a small shop for everyone on the ward. While it was only a limited number of items, it allowed patients to continue preparing their own food. After this, I understood from Marion that an online shop was considered but never arranged. Following this, I believe that it was decided that *'trolley food'* would be provided. However, this was then changed to staff on the ward preparing meals for patients. This meant that Marion's mealtimes changed, with the evening meal served at 16:00 – 17:00 to fit in with staffing and staff breaks. Due to this, Marion told me that she did not want to have lunch at the usual time as this was too close to the evening meal. So, she started eating brunch around 11:00, instead of breakfast and lunch, so two meals a day rather than her usual three.

174. Staff and investigators do not seem to have counted this as a 'change', but this would have been a significant change for Marion as food was very important to her. For those isolated during the COVID-19 pandemic, food could be a way to break up or brighten the day. Moreover, the type of meals prepared – such as bacon, mash and peas – were not ones that Marion would have cooked herself.

175. Marion could not always get the snacks that she would normally buy from the shop, which were things that she usually used as a way to self-soothe daily. This was different from the previous lockdown on Aurora Ward, when Marion and Patient C had done a massive shop to stock up in case there was a lockdown, or the lockdown had

been shorter, and she had enough food to continue self-catering. Staff appeared unaware of these issues. The investigation noted that *'There was no evidence that recognition of the challenge to those who used food as an element for self-soothing during this time was taken into account'* **[Page 48, PSII].**

Patient C moving

176. In the days leading to her death, I had a telephone call with Marion when she told me that her friend, Patient C, with whom she lived on Aurora Ward, had *'gone'*. Prior to the lockdown, she had told me that Patient L was going to come to live with her in Aurora Ward and had started to have socialising visits, but there was no definite time for when Patient C was going to move out of the flat in turn for patient L to move in. It became clear at the inquest that the date that Patient C moved out was 2nd March 2022.

177. It is of note an entry made at 04:51 on 3rd March 2022 by the ward's staff, with reference to events around 21:00 – 22:00, read that **Marion** was observed awake in her bedroom watching TV, noting in conversation that she would **miss** sharing the flat with her flatmate **[Page 300, EPUT medical records].**

178. Reading the Aurora ward records for Marion over this period, there was no note that Patient C was moving out of the flat that she had shared with Marion since September 2021. Not one staff member including Marion's psychiatrist or psychologist noted the impact of fear of abandonment when Marion was already under stress due to other changes that had occurred. This was not helped by the lack of any Relapse Prevention Plan (RPP) by this point, even though discharge was being actively pursued and was on Marion's mind.

179. In relation to the patient mix on a ward, the 'See Think Act' guidance states that staff should, *'[k]now how patients feel about the other patients around them'.* Unfortunately, this was not the case for Marion's keyworker who had not noticed or asked Marion about this and so did not think that Marion and Patient C were friends. Marion had no warning about patient C being moved during the lockdown. In evidence at the inquest, staff advised that it was not their practice to forewarn either the person involved or anyone they are sharing with that they are going to move. I can understand that confidentiality is an issue, however I believe it would have helped Marion if she had been prepared for this. Marion knew that it would happen at some point, but the

timing was awful for her given the other changes she was experiencing during that ward lockdown, which were largely unrecognised by staff.

180. Staff at the inquest gave evidence that Marion was still able to see Patient C as she was still present on the ward, however, as is evidenced from past incidents involving Marion, these sorts of events could trigger her due to her poor problem-solving skills.

181. Ultimately, the staff did not consider Patient C's move as a potential issue for Marion or note that it was one in a series of changes for her that week. The fact of the flatmate's move and that Marion would now be living alone in the flat was not recorded on her notes. Marion's keyworker gave evidence that she did not believe that Marion and her flat mate were even friends. The deputy sister on duty when Marion died said in evidence that she knew that Marion and her flat mate were friends. Evidence was provided at the inquest that Marion and Patient C would get up early, complete chores and sit in the communal lounge before the morning meeting and that after the meeting they would remain in the lounge catching up. Evidence was provided that Marion would have missed them cooking together.

182. Marion's psychiatrist gave evidence to the inquest that he was not aware of this move happening as the flatmate had a different clinician, but, in my view, he went to great lengths to downplay this as a change that would affect Marion and was highly defensive.

Court date moved

183. On 1st March 2022, Marion was informed that there would be a Jersey court hearing on 4th March 2022 (to review her care as part of the six-monthly reviews). A record is made by ward staff that she was advised this would take place at 10am and that everything was *'in hand'* **[Page 52, Inquest Bundle 2, Ward Round notes].**

184. However, on 3rd March 2022, Marion was informed that her hearing had been moved to 31st March 2022. I believe that this caused her stress due to what I now know to be her poor problem-solving skills.

Due to be discharged

185. Arrangements were being made to have Marion assessed in preparation for her discharge, and to secure her a suitable place to reside. I believe that the fact that Marion had self-harmed in a previous transition should have been better appreciated, especially because her social worker had noted at a ward round that Marion had not put any thought into what life would be like in supported accommodation. The social worker did not liaise with me about the accommodation, even though Marion had given her permission to do so on 11 February 2022, no attempt was made to contact me before Marion's death more than three weeks later – even though a potentially stressful assessment with an accommodation provider was booked in. No one obtained brochures for Marion to read or to show her the accommodation provider's website. I did not know the name of the accommodation so I could not look it up myself.

186. I believe that Marion should have received more support and guidance through this next major transition. I also believe that before any such arrangements were made, that the Relapse Prevention Plan should have been completed to inform any discharge steps and address any discharge risks. I understand that this would have been a one-month process. I understand that this was the plan made by **Mr D**, as noted in a session on 29th December 2021 **[Page 11, Mr D witness statement, 1st August 2022].**

Risk assessment on 3 March 2022

187. With all of these key changes to Marion's routine, I believe she needed psychological support particularly during this period. There is no evidence that she had any further meetings with **Mr D** after December 2021.

188. On 3rd March 2022, Marion completed a piece of homework for her self-forgiveness handbook. I understand that it was uncharacteristically brief and not up to her usual standards. I understand that it contained grammatical and spelling errors and did not make much sense. As a result, an appointment was made to discuss this answer on 8th March 2022. I understand that an entry from EPUT's medical records states:

My Assistant Psychologist, **Ms G** *emailed me (as I was recovering from a broken shoulder and was working remotely soon after my accident on 20th February 2022) with Ms Michel's last answer on Step 6. The last question being 'In what ways do you plan to live virtuously in the future?'*

I noted that her response to the last question, which had been handed to **Ms G** *on a scrap piece of paper, was a brief response only.*

Responding to Lack of Sleep she stated "I need to my sleep quota is good and not be feel tense; be able to reason with things; to use my DBT Skills TIP/Shop etc. to use Pro's and Con's to reason arguments out; not getting emotionally overwhelmed and being able to go into wise mode; Use mindfulness-deep breathing exercises."

It was a matter-of-fact decision to request for us to arrange a team's meeting on the 8th March 2022 to discuss her last albeit very brief response to the last question on Step 6, with the intention then to arrange a session to review all her responses (steps 1-6) to give Ms Michel opportunity offer any reflections on these moving forward and to arrange for another session in order to commence the RPP, as had previously been discussed.' **[Page 124, Inquest Bundle 1,** **Mr D** **].**

189. Further, I understand that on this day a Risk Profile form was completed for Marion. This did not contain any sufficient details about Marion's risks and there are errors within it. For example, 'Early Warning signs of relapse' is marked 'Yes' when really this should have been marked 'No'. 'Impulse control and Impulsivity' as a historical risk factor is also marked 'No' when it should have been marked 'Yes'. There is no mention of EUPD traits, and the inference is that staff on the ward understood that it was psychosis that led to both the assaults of Marion on her partner, rather than just the first one. At the inquest, the individual who performed the risk profile assessment on Marion on 3rd March 2022 conceded that it was not a thorough assessment.

190. At the inquest staff on duty were asked to describe what they expected to see if Marion had a relapse, and they said different things, one was looking for aggressive or a psychotic presentation, the other thought that Marion would go quiet, which was more accurate. I believe that this is evidence of a general staff confusion about Marion's history and relapse triggers and presentation recorded throughout her notes.

Events of 4 March 2022

Staffing levels

191. I understand that on the day of Marion's death, there were two members of staff working on the day shift. One was a senior nurse and one was a health care assistant from the bank staff **[Page 43, PSII].**

192. According to the PSII, this was an adequate number of staff. However, I recall that during the lockdown, most of the patients would be at Aurora Ward. Staff were responsible for meeting all of their needs and they by this point also had to make the patients' meals. I understand that on the day that Marion died – one staff member had been called away to a meeting leaving the other staff member on her own to manage the morning meeting.

Meeting about lockdown

193. I understand that during a communal ward morning meeting attended by both staff and patients on 4th March 2022, the patients were advised that the lockdown on the ward *may* be lifted and that they would be notified of the decision in the afternoon that day. Marion was present for this meeting.

Meeting about housing

194. On 1st March, at a ward round, Marion was informed that she was due to have a meeting for her housing assessment on 8th March 2022. However, Nurse **Ms F** gave evidence at the inquest that she had in fact made the diary entry for this housing meeting as taking place at 14:00 on 4th March. She did not know why she did this. This meeting was very important for Marion and she had been noted, I understand, to have chased the date for her assessment previously. For example, the PSII notes at Page 25 that on 23rd November 2021, Marion had asked her social worker if she had completed the assessment for her accommodation placement, and at Page 34 of the PSII it is noted that on 25th February 2022, during a 1:1 with her keyworker, Marion requested an update on her accommodation.

195. As a result of the wrong diary entry, Marion was told at the morning meeting on 4th March 2022 that she had an appointment that day with a supported accommodation provider at 14:00.

196. The fact that it was a meeting of some consequence (regarding where she may live on discharge and being assessed by the supported lodging staff) should also have flagged that this could be a big deal for Marion, given her history and need for a routine.

197. When Marion was told on the day that she died, that the assessment meeting was unexpectedly brought forward (in error) I believe this was highly stressful for her and no support seems to have been offered to her in advance of the meeting that was planned for 8th March or by staff on 4th March. I think that she could not picture the place in her mind and may not have known the expectations on her. There was a lack of understanding by staff at how stressful this was for a patient like Marion and that she struggled to 'solve problems' such as this one.

198. I would argue that staff were also too busy with their additional tasks due to the lockdown, as their usual duties to take time out to be proactive with Marion, who had come to the staff office on several occasions to check things after having been told about the meeting. It is important to note here that Marion was very organised and proactive about her appointments and treatment – and she kept a note of the housing meeting date in her diary. The staff should have known that Marion did not usually get her dates mixed up, and they should have investigated the actual date of the housing meeting further given the discrepancy. I think that this was a missed opportunity to read this as anxiety and to be proactive about it – for example, by checking with her social worker, or looking into any records where such information would likely have been recorded, such as MDT records. Given that one staff member was left to do the morning meeting while the other went to another off-ward meeting there was no time.

199. The alleged change of the appointment for the housing assessment was, I believe, the final straw.

<u>Issued a knife</u>

200. At 11:15am, Marion requested a large knife to prepare her lunch. She was issued a knife, which I understand was 18cm in length.

201. I came to learn after Marion's death, that the major change for Marion after she transferred to Aurora Ward was that here she would have unsupervised access to knives. I never knew this.

202. I understand that there was no new assessment process to look into this risk when she was transferring to the ward, or anytime thereafter. The last assessment that Marion had had concerning sharps was a 'Sharps Cooking Assessment on 7.06.19', an outdated functional staff risk assessment concerned with only whether she could use a knife safely in cooking. This was standard procedure at Brockfield House at the time Marion died. The staff on Aurora ward were aware that the Sharps Cooking Assessment had been done and relied on this and therefore were not required to conduct their own assessment when they issued a knife. There was no sharps assessment which included the individual's history of sharps use either against others or themselves.

203. Staff on Aurora ward had access to a general HCR-20 risk assessment in relation to Marion and a Risk Profile completed by the keyworker, but I believe that they did not actually know a lot of detail about Marion's previous history of self-harm. Certainly, they could not recall it when questioned by the police on the day that Marion died. In an initial statement to the police ward staff referred to a past history of jumping from heights and the police noted that: '*During the previous 3 years, staff did not believe she had tried anything like this before, although they thought that there had been an incident 3 years ago when she first arrived. They could not provide any detail on what these incidents were but indicated that they referred to self-harm/suicide.*' **[Inspector [I/S] Witness Statement, p. 10, Inquest Bundle 1].** As detailed below, the PSII found that Marion's HCR-20 assessment was outdated at the time of her death.

204. I understand that a sharps signing out sheet disclosed during the inquest details that Marion had been issued with a knife by staff three times since December 2021. However, this was odd because staff later said that Marion would usually request a knife three to four times a week. Evidence was given at the inquest to confirm that the signing in and out of knives would often be missed and that the procedures in relation to the issuing of knives were sometimes – if not often – not followed on the ward. I understand that at the relevant time, EPUT had a daily security nurse system in place, so that the staff member that handed a sharp item to a patient was not the person who actually signed or logged the sharp item out. This was a complicated system that was prone to failure as busy staff would fail to communicate with each other about, and safely monitor, the issuing and returning of sharp items.

205. Evidence was also given that staff did not specifically ask what patients were making when they asked for a knife and why they needed the size of knife that they were asking for. Patients could therefore request any size of knife and it would be given to them. The largest knife that patients could request was 18cm/7inch blade. Evidence was given that the knives in use at that time were dagger-type knives and that the rounded-end 'safety knives' were not being used. Evidence was also given that no checks were made on patients who had a knife (outside the normal hourly observations) and that the practice was that it was up to patients to return the knife to staff.

206. A further formal risk assessment was not carried out upon Marion's transfer to Aurora Ward. Staff gave evidence at the inquest that they completed a brief risk assessment when patients were going on leave to check they were fit to go out. Nurse **Ms F** gave evidence at the inquest that, at the time of issuing the knife to Marion on 4 March 2022, Marion was displaying a '*normal presentation*' and that she did not detect any *'irritability or anger'* in Marion. **Ms F** also gave evidence during the inquest that she was aware that Marion did not tend to show signs of anger or anxiety when she was acutely unwell, and that Marion could be very unwell without showing any of signs of this.

207. **Dr B** gave evidence that risk assessments would have been discussed during multi-disciplinary team meetings. Counsel for EPUT was tasked with checking MDT records, and could find no record of any discussion about risk assessment in relation to knife use by Marion discussed during any ward round meeting since Marion moved to Brockfield House.

208. What is further concerning is that there was no curiosity about why Marion needed a knife and whether she even had any food items to prepare given that her last food shop was on 8 February 2022. When staff cleared Marion's fridge two weeks after her death, they found what would have been fresh vegetables and sauces in the fridge and some frozen food in the freezer with some tins in the cupboard **[Page 43, PSII].**

209. In her statement to the police, the staff member who found Marion, seems to have forgotten that Marion had asked for a knife to make her own lunch. She stated that she went into the flat to complete the hourly observation check and to ask Marion if she wanted to have an omelette that the staff were cooking for the patients for lunch

– even though she issued the 18cm knife to Marion because Marion said she wanted to make her lunch.

210. On the Knife Signing Out sheet, a few of Marion's previous occasions of having a knife were recorded. From this, it is easy to see that she always returned the knife within about 15-30 mins of using it. Therefore, the fact that she had not returned it on the day she died could have raised alarm bells as this was unusual behaviour. If EPUT had a more through risk assessment this could also have been included in it. The failure of staff on the ward to adhere to the protocols and policy on issuing sharps and EPUT's apparent lack of auditing of these signing out sheets, their reliance on EPUT's assessments for patient's knife use as only functional and completed almost three years earlier and having been assessed elsewhere, seems to have led to a lack of any real assessment or commonsense being applied when it came to handing knives to patients. This was a forensic secure unit where many patients would have committed crimes using sharps. I believe this whole situation was something that EPUT should have been aware of and rectified prior to my sister's death and that those inspecting this service should have flagged this up.

211. Marion was unfortunately found in her bathroom around 12:00 to 12:15 with the records of the exact timing being unclear, with several stab wounds, which she inflicted using the knife that was issued to her at 11:15. I note that there was a reference to staff being unable to open the toilet door for about five minutes.

Emergency response

212. The PSII reported that there was a delay in the emergency medical response to Marion, due to confusion about the type of emergency that this was. It notes at Page 40:

When she was discovered, staff moved Marion from the toilet area into the corridor of her flat area. When they visited Aurora Ward the investigators made note of the confined space Marion was found in, and the narrowness of the corridor. Four staff attempted CPR. There was confusion as to whether the defibrillator was shocking or not, and following the incident when a senior manager met with the staff involved to complete the resuscitation form, she found that some staff were saying it was shocking and others were unclear whether it had shocked or how many times. Reflecting on this later, she concluded that it hadn't shocked, and amended the form the following day when she returned to work.

Following the incident, a decision was made to add resuscitation forms to grab bags so they are available at times of incidents requiring their use.

The first doctor at the scene noted that there was blood clotting around Marion's neck, indicating that some time had passed since the moment of stabbing/time of the incident to when she was found.

213. I understand that the ambulance was called between 12:17 to 12:20 **[p. 538 EPUT medical (Resuscitation Event Report Form); and p. 78 Inquest Bundle 2],** and that the first paramedic arrived on scene at 12:22 **[PSSI, pp. 6 – 7].**

214. I understand that an entry was made at 13:01:15 stating, '*recognition of life extinct.'* **[p. 88, Inquest Bundle 2].**

After Marion's death

215. I received a call from Marion's social worker around 13:00 on 4th March 2022 to say that Marion had hurt herself and the paramedics were in attendance. As I mentioned in my witness statement for Marion's inquest, I knew that Marion was likely to have cut herself but imagined that she may have used a DVD, as I did not think that she would have unlimited access to a knife. I recall saying to **the SW** at the time, *"[I]t's this bloody lockdown."* I informed my parents and said I would get back to them and prepared to pack a suitcase to go to Essex as I hoped that my sister would be admitted to hospital. I also had to inform my work that I would not be at work. At about 14:30, I had not heard any more information from anyone, so I called Marion's social worker again and it went to voicemail. I left a message. By this time, I was getting very worried.

216. A police officer from Norfolk Police came to my home about 15:00. As soon as I saw the police car, I knew that Marion had died. The police officer was supportive, however as this was just a request from Essex to Norfolk authorities to carry out this task, the officer involved did not know any substantive details about my sister's death.

217. I had not heard anything from Essex police or EPUT, so around 18:00, I called Essex Police to leave a message requesting a call. I did not get a call from Essex

police until the following day, 5th March at around 21:00, about 36 hours after Marion had died.

218. At about 21:00 on 4th March, Marion's social worker from Brockfield House called me. I believe she did this not out of protocol but because she felt bad not returning a call that I had made earlier, before the police arrived. However, I am still not clear on who should tell relatives what after a death. She was able to answer my question as to where Marion's body was likely to have been taken and the name of the undertakers, but she did not give me any details of what had happened. She also advised me that the chaplain had gone in the ambulance with Marion after she'd died, which was comforting information.

219. In the end, it was a duty undertaker who I managed to speak to on the afternoon of 5th March, who was able to answer some of my questions and to advise me where my sister was. I will be eternally grateful to that man who was compassionate and gave me his time. Even though I was the recently bereaved person, in shock, I had to ring around different organisations for even the most basic information. This was the start of a theme that would continue in all aspects of the aftermath of my sister's death.

220. The social worker for my sister at Brockfield House, was helpful in letting me choose and identifying clothing for my sister and taking this to the undertakers as this was in Chelmsford. She also called me to arrange to collect Marion's belongings. I was able to give my views as to what I wanted to happen with some of her possessions– i.e. her toiletries and beauty products to be given to her friend. I was also invited by the chaplain to a memorial service for Marion at Brockfield House. This was scheduled for a different day to collecting her belongings which I was grateful for.

221. When I attended with my partner to collect my sister's belongings, I was introduced to some staff members on Aurora ward. The Chief Executive, Paul Scott and **[I/S]** Associate Director for Specialist Services were also present in the background. On that day, I told staff that I did not blame them, that this was what my sister did. There seemed to be relief all round. My sister's belongings had been packed, making it easy for us to take them. We were given some time in her room on our own. I was asked about certain items such as her TV, trolley bag and mobile phone and other items, which I agreed should be given to other patients who did not have them. This part of the process felt well organised and ran as smoothly as it could do.

222. The memorial service held at the unit was also positive. It was arranged by the chaplain in consultation with me. She was very supportive and on reflection she was the only person I trusted at EPUT. I also appreciated the fact that she had gone with Marion in the ambulance after she died. It was clearly understood that other patients needed to be helped with Marion's sudden death and needed a way to start to process this and to celebrate her life – or the part of life that they knew about. This was attended by about 40 patients and staff. I gave a reading about Marion and other patients and staff also spoke about their memories of Marion or read out poems they had written. A rose bush was planted in the grounds.

223. It was also at this event that I started to question what had gone wrong. The psychiatrist seemed to have no concept of why what had happened, happened, describing Marion as a *'model patient'* as he continued to do from that point. After a while and later when I read all the expert reports and records, I reflected that staff had the most information anyone had ever had about Marion's mental health history and likely risk factors, but that still they seemed surprised that this was something that she was capable of.

224. In early November 2022, I received a call from my sister's original social worker to say that an envelope full of condolence cards had been found in a drawer in the office. He apologised about it and said that it may have been that this was supposed to have been handed over to me at the memorial service and that this had been overlooked. I agreed that he should send them to me. I also said that I had not received the investigation report which had been due mid-October, he said that he would chase this with the liaison person, **Ms H**. I then received a large envelope date stamped 9th November 2022, containing 7 condolence cards from patients at Brockfield House. I was saddened and felt angry for those patients and friends of Marion who had thought that their cards had reached the family.

PSII: investigation and report

Process

225. On 21st March 2022, I received a letter from EPUT's Patient Safety Incident Management Team advising that EPUT would be *'reviewing Marion's care'* and gave me the contact details for the Family Liaison Officer (FLO), **Ms H** who

turned out to be the senior line manager for Marion's social worker at Brockfield House.

226. This obvious conflict of interest was not mentioned in the letter, but Ms H did make me aware of it when we first spoke. There was no reference in the initial letter to an investigation and I was not given the names, roles or qualifications of those conducting the investigation or the terms of reference. This letter and accompanying EPUT booklet 'Information for families following a bereavement' dated June 2020 was all I received. The booklet did have a page on investigations, but the letter only used the word 'Review'.

227. In the' Investigations' section of this booklet it said that *'If a serious incident investigation is to be held, we will inform you and explain the process to you. We will also ask you about how and when you would like to be involved. We will explain the terms of reference for the investigation'*. I never received written notification as described in this booklet from EPUT, so I had no idea about an investigation in relation to Marion or what information I was entitled to until I had a discussion with a senior case worker at the charity, INQUEST who gave me this information and advised that in Marion's case there was likely to be a full investigation.

228. Had I not been supported by INQUEST I would likely have been at a complete loss as to what to do. The caseworker explained my rights and that I could find out who was conducting the investigation and their role and whether they worked for EPUT. At this stage I was not legally represented.

229. I found out who the investigators were by asking the FLO for their details then contacting one of them directly. The investigators were Ms I Senior Investigating Manager for EPUT, who told me that she was an occupational therapist, having qualified as such in 1987, who was retired and worked now as an investigating manager for EPUT. She said she had no connection to Brockfield House or the services it provided.

230. The other investigator was [I/S], a Consultant Psychiatrist, who was at that time a Consultant for Old Age services in the North of the Trust. He had been a consultant for 20 years. At that time he was the Deputy Medical Director for the Trust. He was also a member of the Royal College of Psychiatrists. He had

conducted a number of investigations over the years. He was stated to have no connections with Brockfield House.

231. Once I had the investigators emails, I contacted one of the investigators directly. This is because I did not have faith in the EPUT FLO and did not see her as impartial, as she was the line manager of the social worker for my sister. I also did not find her very effective. I often advised her that I preferred information from her in writing, but I did not receive this information much of the time and she continued to call me. Her main focus seemed to be wanting to have 'heart to hearts' with me. I confided in her at first but after a few calls I did not want to confide in her anymore as I had my own support network. I also found that she was not very effective at keeping me updated on the progress of the investigation or passing on information to the investigators, such as when I told her I preferred for Marion to be referred to by her first name in the PSII report.

232. I was then contacted by one of the investigators to ask me the same question as there had clearly been no communication. I believe that the FLO was appointed to me due to me saying early on that no one was to blame, and due to her having the same professional qualification as me. If this was how the decision was made, then it did not take account that my views may change once I received more information.

233. On what would have been Marion's 57th birthday, I received an email from her saying that *'the Social Work Team will be thinking of you and the family at this time'*. Whilst the thought was there, this also emphasised that she was part of the social work team at Brockfield House. After her message about the PSII report being ready in December 2022, I did not hear from her again until about a week before the inquest when I got an email asking if I would like her to support me at the inquest. This suggestion seemed laughable to me.

234. I had some questions based on what my sister had told me around that time, and I sent these in the end directly to one of the investigators, **Ms I**. They were included in the investigation report. I will never know if the investigators themselves would have contacted me, had I not contacted them.

235. I was first advised by one of the investigators that the draft report would be completed by July 2022 and so they were aiming for August 2022, however this

deadline came and went. After the initial pre-inquest reviewing hearing at the coroner's court a date of 'mid-October 2022' was given by the coroner.

236. As someone who has attended court in a professional capacity, I found the setting of this vague date unusual, as I have been used to being given a precise deadline which if missed has consequences. Mid-October came and went. I was not kept informed by the EPUT FLO – which I believe was one part of her role. On 21st December I was visiting my parents in Jersey for Christmas and missed a call from the FLO. She advised in a voice mail message that the PSII report was ready and was being sent out.

237. In my view the timing of this was very poor, this being the first Christmas since Marion had died and the fact that most people would not want to read the report, even if they had been waiting for it, around this time. From my perspective it felt like this was someone's last working day before Christmas and they were ticking this off their 'to do' list before they finished for the holidays. In my view little thought had gone into the impact on my family of receiving this call at this time.

238. I returned home to the UK after Christmas, but by the first week of January 2023 the report still had not arrived. I received no call or email to explain what had happened. In the end I chased it up via my solicitors who were advised that there had been a delay. On 12th January 2023, I received a call from my partner to say that an A4 envelope with the report in it had arrived. I was on my way to Jersey that day, therefore had to then arrange for it to be emailed to me. This was a very inconvenient time for me to receive the report due to a family member's condition deteriorating. I was given no notice that it had been posted, having heard nothing from EPUT since 21st December 2022.

239. The accompanying cover letter with the report dated 11 January 2023, referred to me as the client who had died: *'Dear Ms Michel, I am writing to confirm that the investigation into Karen's care has concluded and as requested I enclose a copy of the investigation report.'*

240. My expectations were not high by then, but this just seemed yet another unacceptable blunder from a department whose job it was to deal with complaints and investigations. I did not get a sense that anyone was thinking about the impact of this

report on the family members – this was a long awaited but also anxiety provoking document, and it was not a neutral document for the receiver.

Findings

241. The PSII made findings in relation to three distinct areas of concern.

242. The first area concerned 'Morning Meetings' and that staff at this meeting had relayed what turned out to be wrong information to Marion about her assessment by Kemps Place a possible supported accommodation in Norwich.

243. The second related to 'Care and Service Delivery Problems/Weakness' which were noted to be the lack of a sharps assessment and the lack of a local area protocol for the use of sharps, and a lack of MDT approaches in this respect which meant that it was for the occupational therapist to conduct sharps assessments and then report to the MDT. The investigators noted that a risk assessment would have been useful in relation to progression planning for her access to sharps. Another point of concern was that staff had not noted in the logbook every time Marion (or any other patient) had had a knife issued to them on the ward.

244. It is to be noted here that alongside this missed opportunity, the investigation found that Marion's HCR-20 risk assessment was out of date at the time of her death: *'HCR-20 was last updated in August 2021 in preparation for Marion's transfer to Aurora ward. The investigation found no evidence that it had been updated in February 2022'* **[Page 49, PSII].**

245. The third area of concern related to the emergency response on 4th March 2022. The investigators noted that there was confusion at the time of the incident when the pin-point alarm was raised as it was not clear to the duty doctor whether it was a medical (doctor required to attend) or a mental health (ward staff are trained to deal with this). It was noted that the site officers report stated that a psychiatric emergency was called, however the Datix stated a medical emergency was called. This led to a delay in the duty doctor attending the scene. In Marion's case it was noted that it is unlikely that her attending sooner would have had any impact on the outcome for Marion, but it may have done in another case.

246. I did agree with these areas of concern; however, I thought that in the first failing area, only a few of the areas of change that I had raised were noted and many of the issues I had raised did not feature. The authors did not raise issues such as the COVID-19 lockdown, lack of recording of 'changes' that Marion experienced such as the date the flat mate moved out. I felt that there were other findings that could have been made and a higher level of scrutiny and probing. There was no reference to the delays in formal discharge planning.

247. There did not seem to be any triangulation of issues raised, what staff said was accepted and that was that, even if it appeared to the reader that what they said should have led to another question or this did not make sense. I believe an independent investigation would have probed more.

248. It is notable that even at the inquest, when the PSII author was questioned, they conceded that in hindsight that should have given more consideration to the cumulative impact of the changes that Marion went through in the lead up to 4th March 2022, stating that: '*In hindsight I think we should have made that clear in the report, although each of the components were discussed, we weren't able to find anywhere in the records all of them were discussed as a whole and the impact that they together would have on MM.'*

249. I also note that Marion's full diagnosis was not mentioned by the investigators – no mention of her paranoid schizophrenia being 'in remission' and not mention at all of EUPD traits. Other areas not picked up was the confusion amongst MDT staff about the clinical understanding of Marion's mental health state prior to Marion's Index Offence which ended with her going to Brockfield House (as opposed to her mental health presentation on the first occasion she hurt her partner in 1999). The investigators did not notice this, and they also repeated wrong information about a *'quick relapse to psychosis'* and wrong information about Marion's reasoning in the run up to her 2018 offence regarding her partner's other relationship. I did not think that my question about the Relapse Prevention Plan timing was answered clearly.

250. In the incident summary it does not state the time the ambulance was called. You would expect this to be in a document like this. I believe that there was some discrepancy amongst between staff as to whether the defibrillator used in resuscitation attempts had been shockable or not. Some staff had said that it had shocked, and

others said that it had not. The following day the report on this was changed to record that the machine had not shocked.

251. I knew that I could meet with the Investigators but chose not to as I did not have a lot of faith in the system by then.

Inquest and civil claim

252. I was briefly informed about the coroner's involvement by the duty undertaker that I spoke to on 5th March 2022. The following week I received a call from a coroner's officer about what had happened and the Inquest process. I was advised of the name of the coroner's officer allocated to Marion's case, who was in the Complex Inquests team. During this call I heard for the first time that there was likely to be an Article 2 'Jury Inquest' – this was not something that I was familiar with, and that the final decision about this would be up to the coroner. I was also told that I could get a solicitor to support me in the process. I was also advised that there would be an initial hearing to open the inquest process. I could not attend this as I was in Jersey by this time. I was given information about the post-mortem and when this was likely to take place. Following this call, I received an email with information about the Inquest process. This included a link to the charity INQUEST's booklet. I was given both telephone and email contact details for the allocated coroner's officer and he was good at getting back to me if I had any queries.

253. I attended (virtually) the first Pre-Inquest Review Hearing (PIRH) alone as I was not represented yet, but then at the next PIRH I had a solicitor. By attending these I was able to see the lay out of the coroner's court room. Some months prior to the inquest taking place, the coroner's officer changed. This was communicated to me and the new person in the role got in touch and introduced herself to me. She was also present at the inquest and was kind, helpful and supportive.

254. The senior caseworker from INQUEST was the other main person that provided me with information about Article 2 inquests. She explained the process and how other families that the charity had worked with experienced these and the different levels of involvement families chose to have. She listened to me talk early on about the mixed feelings that I had as to whether there was anyone to blame for Marion's death given her history. She emphasised the importance of having a solicitor and discussed the different options – either finding a solicitor who would be funded by legal aid or one

that would be funded by an eventual civil claim. She liaised with different solicitors and found one to represent me. She explained the legal aid process and how it had recently changed following a long campaign by INQUEST. Even when I did engage a solicitor, she kept a link with me and spoke to the solicitors and attended key meetings that I had with them leading up to the inquest itself. About a week prior to the inquest hearing, she sent me a helpful checklist of things to consider, both emotional and practical, before the hearing.

255. I chose to have a high level of involvement in the inquest process as I wanted to represent my sister. I read all the reports provided in the bundles, liaised with my solicitor about any queries that I had and attended all eight days of the inquest hearing in July 2023. This was very difficult and took a lot out of me personally, but given my professional experience as a social worker, I believe it was not as daunting for me as it could have been for other people. I felt that it was important for me to be involved so that I could ensure as much as possible that questions that I had were answered. I chose to read out a pen portrait of Marion at the start of the injury, while her photograph was shown on the screen. It was very important to me to depict Marion as a person and an individual.

256. When I received the PSII report from EPUT, the only documents available to me were the Jersey court reports. This made it difficult to respond to the PSII. My statement was due in April 2023, but by that time there were still a lot of documents that I had not received. Even in the week leading up to the Inquest I was still receiving documents from EPUT. A further bundle arrived on 20th June 2023, and another key document after this. This makes it very hard for families and their legal teams to get a grasp of all the information and try to make sense of it and see where the gaps are. Given that all this information should have been available for the investigators who produced the PSII, I do not know why EPUT took so long to provide it to my solicitors and the coroner and why this happened over time and not in one go. I would like the Inquiry to ask this question of EPUT.

257. I did formulate a response to the EPUT investigation; however, the initial draft of this was based on the information from the Jersey court reports – so my response focused on Marion's diagnosis, history and prognosis. I kept having to update it. In the end I gave up and waited for the issues to be raised at the inquest. In my view, this was a more effective approach as I do not think that the investigators would have probed more on the questions that I had asked them.

258. Many of the witness statements of EPUT staff were due in September 2022 but I did not receive them until March 2023 or later. There were many delays to the inquest process. Dates slipped, the PSII report was delayed with no substantive reason given for the delay, which then lead to the inquest being delayed. Marion's inquest took place 16 months after her death. The EPUT Action Plan (produced by EPUT to persuade the coroner that things had changed since Marion's death) was only shared during the inquest hearing, not giving much time to consider it. My legal team and I had to consider it at the end of the day after a hearing. I believe that this could have been made available earlier and then amended if there were any issues that came up during the inquest.

259. At the inquest, I had support from my friends, my partner and from the senior caseworker from INQUEST, as well as my legal team. This support in general and having someone to attend the inquest hearing with you as much as possible was crucial. This is a very difficult process for families.

260. I felt lucky to have the coroner that I had, he was professional and probing. I have heard from and read other families' accounts who felt that their concerns had been shut down by coroners and that despite failings, no Prevention of Future Deaths reports had been made in the inquests for their loved ones.

261. Families are told repeatedly that the Jury Inquest is an inquisitorial process and not an adversarial one. However, this is not how I experienced it. I attended with one supporter each day, alongside counsel and a legal executive. EPUT usually had at least 5 observers, sometimes up to about 10, as well as their solicitor and counsel. Those observing were senior managers and staff who were due to give evidence the following day. I did not want to talk to any of these people, the only person I spoke to was the chaplain who had arranged the memorial for my sister.

262. The jury returned their finding on the last morning of the inquest. In marked contrast to the rest of the inquest, on that morning there was no one from EPUT in attendance at the coroner's court save for their legal representatives. This does not give the message to me that this was an organisation that wanted to hear feedback or criticism or that cared.

263. The EPUT investigators did not come across as well trained to give evidence. One of the investigators burst into tears before they gave evidence, likely due to nerves, but this did not come across well to me. In evidence they appeared to agree with almost everything put to them by Counsel for EPUT and the family.

264. The report that Marion's forensic psychiatrist throughout her time at Brockfield House, had prepared for the coroner was very brief. This was in marked contrast to his reports in the criminal proceedings for my sister, which were much fuller. In his evidence **Dr B** came across as not willing to concede anything – even when common sense queries were raised with him and when the coroner was asking him questions. This attitude did not reflect well on him or EPUT (even though he no longer worked for them at this point). One of the many things that **Dr B** would not concede, was any criticism of his use of the term 'model patient' in respect of Marion. He stuck by this despite the reality that no such person exists and that if they did these patients would not die in the way my sister did.

265. At the end of all the evidence and summing up, the jury was directed by the coroner as to the parameters of the findings that they could make. In Marion's case, following discussion with both EPUT and our counsel, the coroner directed the jury that they may, if they agreed, use the word 'possible' in relation to the issues raised and not 'probable', when determining whether their was a link between any identified issues and Marion's death. The jury returned a narrative conclusion. They agreed that in four out of the five areas they considered, that EPUT failings possibly significantly contributed to Marion's death. Marion's final death certificate was changed because of the inquest findings. The jury found:

'We conclude that Marion Michel took her own life but we were unable to determine her intention at the time she did.

a. *Aside from the 'functional' sharps assessment conducted by the Occupational Therapist in June 2019 on Fuji ward, there was an absence of any further specific risk assessment of Marion, in respect to her supervised access to knives on Fuji ward, in the context of Marion's history of self-harm and violence directed at others involving the use of knives.*

We agree with this statement but heard no evidence that this contributed to Marion's death, as there was consistent supervision.

b. *There was an absence of a focused risk assessment with respect to Marion having unsupervised access to knives prior to her transfer to Aurora ward in mid-September 2021 in the context of Marion's history of self-harm and violence directed at others including the use of knives.*

We agree with this statement and concluded that this possibly contributed significantly to Marion's death.

c. *There was an absence of a focused risk assessment with respect to Marion having unsupervised access to knives following her transfer to Aurora ward in the context of Marion's history of self-harm and violence directed at others including the use of knives.*

We agree with this statement and concluded that this possibly contributed significantly to Marion's death.

We also concluded that inadequate processes and poor controls around access to knives increased the possibility of this.

d. *Given what was known by clinicians and staff on Aurora ward with regard to Marion's capacity, historically, to suffer sudden and extreme deterioration in her mental state leading her to inflict extreme violence against herself or others, was sufficient or insufficient consideration given to the known potential triggers for such deterioration (such as fear of abandonment and sudden changes to plans or routines).*

We concluded that insufficient consideration was given to the known triggers for deterioration.

We further conclude that this possibly contributed significantly to Marion's death.

e. *In the context of the above, do you consider there was a missed opportunity for staff to consider the cumulative effect on Marion's mental state of issues including the effect of the lockdown, Patient C leaving the shared flat, the (erroneous) information that the accommodation meeting was being brought forward to the afternoon of the 4th of March and the postponement of the Jersey court hearing.*

We concluded there was a missed opportunity for staff to consider the cumulative effect of changes on Marion's mental health.

In the absence of a clear clinical explanation for Marion's death, we concluded that this possibly contributed significantly to her death.'

266. I secured a settlement (liability not admitted) with EPUT in 2024, following the inquest.

Documents and Terms of Reference

267. I do not at this stage have any issues to raise with the Inquiry's TOR, but make a note that this view might change as the evidence develops. The only documents I would like the Inquiry to seek to obtain from EPUT are:

- Original HCR-20 Risk Assessment dated 12th April 2019; and
- The last HCR-20 Risk Assessment in August 2021; or
- If the documents cannot be located, an explanation from EPUT as to why they are not available.

My views on and recommendations for change

Positive aspects of care

268. I think the DBT and other groups and activities on offer at Brockfield House were overall positive. They give people tools to understand and manage their mental health and feelings. This seems a positive and proactive and the DBT practitioners and team offering it seemed to be very dedicated. However, there was no real 'stress testing' of patient's use of DBT in real life situations with support from staff. There should be more guided practical application once patients have completed the cycles or as they are coming to an end. There was a screening tool, but this is not the same, in my view.

269. The occupational therapy programme also seemed good and tailored to individuals' likes and dislikes. Marion had a good rapport with the occupational therapists.

270. Marion felt very bad about her assault on her ex-partner. She asked the forensic psychologist to help her with these feelings and when her ex-partner was in the UK at the end of 2021, he asked to meet with her. They had not seen each other since the assault took place. Brockfield House staff worked with Marion and her ex-partner to plan, and offer debriefs after these meetings. This planning helped the meetings to go well and for Marion to feel a bit better about the situation. This was positive, however, I wonder if Marion coping with this situation was taken as confirmation that she had changed and could cope with change and issues going forward. The meeting with her ex-partner was with a person who was very well known to Marion and who had already voiced that he forgave her prior to any meetings. Therefore, in my view, the risks involved in this situation were very different to unknown situations such as those related to discharge, the lockdown and change to her routine, Patient C moving out of their flat, and the other changes that took place in the week leading to her death.

271. The attention to physical health was excellent at Brockfield House and the medical issues that Marion experienced or raised were always followed up by staff or the duty doctor. If necessary, referrals were made to specialists, and Marion was escorted to attend any of these appointments or procedures. Regular checks were done on a range of issues, especially during the pandemic. Marion was also encouraged and supported to try and stay healthy through diet and exercise in the wider offering of occupational therapy activities.

272. Marion was supported to wean off her sleeping tablets. This was a big achievement for Marion.

273. No other individual or organisation raised concerns with me about any aspect of Marion's care or treatment.

<u>Concerns and recommendations</u>

274. I believe I have detailed my concerns about EPUT already. However, in summary, I believe there was not enough focus or risk assessment in relation to

Marion's individual history, including the possibility and nature of relapse, her history of significant self-harm - especially in relation to sharps, and the risks around discharge. Although DBT was positive for Marion, I query whether there was enough support around this on Aurora Ward, especially during ward lockdowns.

275. I have, by way of an example, identified news reports of further deaths at Brockfield, which give me cause for concern. These can be found at the following links <https://www.essexlive.news/news/essex-news/man-dies-unexpected-circumstances-brockfield-9501264> and <https://www.essexlive.news/news/essex-news/inquest-opens-death-man-essex-10059563>.

276. It is not possible to give a comprehensive and complete list of recommendations at this stage when much of the Inquiry evidence remains outstanding. At this stage and based on my personal experience as the bereaved sister of Marion, I would welcome recommendations addressing the following matters, which should have been **different** in my sister's case:

- There should have been an individual sharps risk assessment which included an analysis of Marion's mental health history and her specific episodes that concerned the use of knives to inflict injuries.

- Staff should have all been informed properly about Marion's mental health history, the factors that could lead to her being triggered, and to the signs and symptoms to look out for in her specific case. These matters should have been clearly and accurately updated and recorded in the tools they used to assess her risks and manage her care and treatment.

- The changes in Marion's circumstances and routine should have been better documented and appreciated by those responsible for her care as potential triggers for a relapse.

- The discharge planning from Aurora Ward should have involved a clearer framework of timescales, processes and planning. This is especially so in Marion's case because she was reliant upon having a routine that she could stick to, and had a history of self-harm following adjustments to her routine and

to moves. I consider that her family should have been consulted more and more involved from an earlier stage in such plans.

- In the lockdowns, the number of days the lockdown had been going should have been clearly and accurately recorded at the start of each patients' record each day, so that staff coming on would have had a reminder of how long it had been going on for and could consider the impact on patients.

- Those responsible for Marion's care should have better appreciated the fact that Marion had in her past admissions made good progress but nevertheless relapsed. She was however referred to as a model patient. These issues should also have been explored further with Marion, and with me (with Marion's consent) more.

- The importance of friendships between patients seemed to be completely underestimated and undervalued by staff. Many people struggle with friendships and so in somewhere like Brockfield House where people are together for years, friendships do develop and are very important to people as they have shared experiences. This should have been better recognised and appreciated by staff. It is likely that in some cases these friendships will continue after discharge and will form important support networks going into the future. Marion already kept in touch with two friends who were former patients that had been discharged, and I think would have kept in touch with Patient C and T.

- Unless there is clear evidence of abuse or an individual who has capacity does not want their family's direct involvement, the family should play a meaningful and active role with decision-making alongside the wider team as the family will be the ones offering support in the longer term. This should include ward staff as well as social workers and specialist roles.

- Trusts should ensure that staff are trained in emergency responses, and it should be clear who should call an ambulance and what personnel should attend to an emergency while the ambulance services arrive. Staff should not wait for the internal medical emergency response team to arrive before they do

this if the patient is clearly in need of lifesaving treatment. Staff should also be trained and kept updated in the use of defibrillators and how they work.

- Investigations into deaths should be independent, to give the best opportunity for scrutiny and challenge of services and to ensure that issues are not glossed over. Independent investigators should not be previous EPUT employees. There should be thematic audits in place to check on issues where there have been failures, and to monitor the changes made as suggested in investigation reports or the like.

- I agree with the charity INQUEST's recommendations in their statement to the Inquiry and I agree with the foundation of a National Oversight Mechanism and the collection of data of deaths in mental health hospitals. I have learned from some of the evidence in the Inquiry that the oversight of mental health inpatient provision is very confusing, and a clearer approach of who oversees investigations and prosecutions when things go wrong is needed. This would also help to build up knowledge in one place about any history of similar failures.

- I believe that many of the themes being explored by this Inquiry are seen in other Trusts. I know for example that there have been a very high number of deaths of in and outpatients with mental health problems in Norfolk and Suffolk NHS Trusts. Any recommendations that the Inquiry makes should be applied nationally to ensure consistency of psychiatric and psychological practices and care.

Impact on me

277. I was and I remain devastated by Marion's death and the circumstances within which she died. I have been affected physically, emotionally and even financially. In the aftermath of Marion's untimely death.

278. Engaging with the inquest, civil claim and this Inquiry have meant revisiting traumatic events. Whilst difficult for me, I believe that I share the same motivation as many of the other families in coming forward for lessons learnt and to bring about change.

STATEMENT OF TRUTH

I believe the contents of this statement to be true.

Name: KAREN ANNE MICHEL

Signature: [I/S]

Date

24 June 2025

ANNEX 1

LIST OF EXHIBITS IN SUPPORT

Name	Organisation	Document
[I/S]	Broomfield Hospital	Post Mortem Report
[I/S]	Sheffield Teaching Hospital	Toxicology Report
[I/S]	EPUT	Statement of ID
[I/S]	Essex Police	Statement 04/03/2022
[I/S]	Essex Police	Statement 04/03/2022
[I/S]	Essex Police	Statement 05/04/2022
[I/S]	EPUT	Statement 04/03/2022 Statement 09/03/2022 Statement 01/09/2022
[I/S]	East of England Ambulance Trust	Statement 07/03/2022

EMT [I/S]	East of England Ambulance Trust	ROLE Statement 04/03/2022
N/A	Family provided	Marion's CV Document
Karen MICHEL	Family – Sister	Questions for EPUT
Karen MICHEL	Family – Sister	Questions for EPUT
[I/S]	EPUT	Statement 27/07/2022
[I/S]	EPUT	Statement 02/08/2022
[I/S]	EPUT	Statement 16/08/2022 Statement 01/02/2023
[I/S]	EPUT	Statement 16/08/2022
[I/S]	EPUT	Statement 17/08/2022
[I/S]	EPUT	Statement 30/08/2022
Mr D	EPUT	Statement 01/08/2022
Ms E	EPUT	Statement 16/09/2022 Statement 14/10/2022 Exhibit KR1 – List of Occupational Therapy Contacts Exhibit KR2 – Non Sharps Cooking Assessment Exhibit KR3 - Sharps Cooking Assessment Exhibit KR 4 – Community Skills Assessment
Dr B	EPUT	Statement 19/08/2022
[I/S]	EPUT	Statement 26/08/2022
[I/S]	EPUT	Statement 31/01/2023
[I/S]	EPUT	Statement 05/02/2023
[I/S]	Essex Police	MG11 Statement 11/08/2022

[I/S]	Essex Police	MG11 Statement 11/08/2022
[I/S]	Essex Police	A124 Referral to HM Coroner
N/A	Essex Police	STORM Incident Log EP-20220304-0500
Police Recovered	Essex Police	Form 4.1-00 CP Records
Police Recovered	Essex Police	Level 1 Observation Record
Police Recovered	Essex Police	Psychology CPA Report dated 05/10/2021
Police Recovered	Essex Police	Medical Report for Care programme dated 09/11/2021
Police Recovered	Essex Police	MDT Report Fuji Ward Round
Police Recovered	Essex Police	Letter Dr B to HM Attorney General dated 28/02/2022
N/A	London Road Surgery, Wickford	GP Summary
[I/S]	EPUT	Medical Report 09/03/2022
N/A	East of England Ambulance Trust	Air Ambulance Patient Care Record
N/A	East of England Ambulance Trust	EEAST Patient Care Record
N/A	East of England Ambulance Trust	EEAST CAD Report 0403221688
N/A	East of England Ambulance Trust	EEAST CAD Report 0403221685
[I/S]	Essex Police	Investigation Coronial Report 19/10/2022 Appendix A – Plan of Aurora ward with annotations

N/A	Essex Police	Phone Download Review of Marion Michel's phone (Exhibit LTJ/3)
	EPUT	Patient Safety Incident Investigation (PSII) Report
N/A	Essex Police	Court Print of PNC Record for Marion Michel
Bundle 3 – Jersey Law Offices Documents		
Various Documents provided by Jersey Law Offices - Pages 1 – 237		
Bundle 4 – Policies and Procedures		
N/A	EPUT	SEE THINK ACT Your guide to relational security
N/A	EPUT	SSOP36 Protocol for Tools, Equipment and Material Security – Secure Services
N/A	EPUT	SSOP25 Protocol for Rapid Response to Emergency Incidents (Secure Services)
N/A	EPUT	SSOP4 Protocol for Inter Ward Transfers Within the Secure Services
N/A	EPUT	Standard Operating Procedure – Forensic Psychological Services
N/A	EPUT	CLP8 Engagement and Supportive Observation Policy (Inpatients)
N/A	EPUT	A guide to Automated External Defibrillators (AEDs)
N/A	EPUT	ICPG1 – Section 4 – Appendix 15 – Coronavirus outbreak management process
N/A	EPUT	CLPG28 Clinical Risk Assessment and Safety Management Procedure
Bundle 5 – EPUT Medical Records (2022)		
N/A	EPUT	Medical Records relating to 2022
Addendum Bundle A: Additional Docs Disclosed by Essex Police		
N/A	EPUT	Risk Assessment Supervised Kitchen Access 01/03/2020

N/A	EPUT	Psychology CPA report 09/11/2021
N/A	EPUT	Letter dated 28/02/2022
N/A	EPUT	Level 1 General Observation dated 03/03/2022
N/A	EPUT	Community Skills Assessment dated 23/07/2020
N/A	EPUT	Occupational Therapy Cookery Assessment dated 26/03/2019
N/A	EPUT	Risk Assessment for unsupervised roll on deodorant dated 01/03/2020
N/A	EPUT	Risk Assessment for unsupervised Kitchen Access dated 01/03/2020
N/A	EPUT	Risk Assessment for unsupervised Key Access dated 16/02/2020
N/A	EPUT	Risk Assessment for Tampon Use dated 16/02/2020
N/A	EPUT	Risk Assessment for Unsupervised Bath dated 01/03/2020
N/A	EPUT	Occupational Therapy Cookery Assessment dated 11/06/2019
N/A	EPUT	Fuji Ward Round (Aurora Ward) dated 01/03/2022
N/A	EPUT	Medical Report for Care Programme Approach Meeting to be held on 9 November 2021
N/A	EPUT	Sharps cooking assessment 11/06/2019
Other documents disclosed		

N/A	EPUT	Excel spreadsheet of Appendix 2 MM Psychometric Test Results 20202022 – To accompany [I/S] s statement