

LAMPARD INQUIRY

SUPPLEMENTARY WITNESS STATEMENT OF MR STUART RINGER

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

1. I make this supplementary statement pursuant to my Rule 9 witness statement submitted to the Lampard Inquiry on 24th April 2025, further to a Rule 9 Request for evidence received from the Lampard Inquiry dated 30th January 2025, in relation to Malgorzata Elzbieta Breczko-Nowak.
2. When submitting my witness statement, I also submitted a letter to the Inquiry, dated 28th March 2025, which set out that the exhibits to my statement were provided as I do not wish to keep re-living the events that lead to Gosia's death, and to aid for a clear and concise understanding of my statement.
3. I also supplied the evidence so that the Inquiry has the opportunity to consider what I believe to be an abuse of power and a clear lack in the duty of care that should have been afforded to Miss Breczko-Nowak. This occurred at Essex mental health services in Brentwood and Chelmsford over a period of 9 years.
4. I have set out in my letter of the 16th April 2021 to [I/S] the head of the Chelmsford and Essex Centre where Miss Breczko-Nowak was having her care co-ordinated from, a clear and open timeline of events. This letter is set out below – Exhibits SR1. It should be noted that I did not receive reply to this letter.
5. It is my belief that an abuse of power carried out by the Brentwood Mental Health team (SEPT) in June 2013. I have set out with full honesty and openness what happened during this period.

6. I believe it is imperative that the Inquiry look at this event, as I believe it was pivotal in how I was viewed 6 years later by the Chelmsford team that looked after Miss Breczko-Nowak.
7. I assert that SEPT made false and serious allegations against me, with a view to placing Miss Breczko-Nowak in a sheltered housing property in Harlow, Essex. They succeeded in placing her in this facility, however it is my understanding that Miss Breczko-Nowak who was an alcoholic, was asked to leave this facility after less than one week, as the facility was “dry”, IE no alcohol.
8. To place a known alcoholic in such a facility was an utter failure in SEPT’s duty of care to that person’s safety and wellbeing.
9. SEPT falsely accused me of harming Miss Breczko-Nowak; I did not. This has left an inerascable stain upon my character, but what I would ask of the Inquiry is to look at the way this false allegation coloured the way Miss Breczko-Nowak living at my property was viewed by the Chelmsford team in 2019.
10. Her care co-ordinator **(care co-ordinator A)** attempted to persuade Miss Breczko-Nowak to make allegations against me – Exhibit SR3 below.
11. I believe that these attempts to drive a wedge between Miss Breczko-Nowak and I, contributed greatly to her anxiety and lead her to drink whilst on strong medication that ultimately led to her death.
12. I was the only person that stood by her when she needed help. Mizz Breczko-Nowak suffered **traumatic events in the past** because of this she did not trust men, I was the only man she trusted, and **[I/S]** **care co-ordinator A**’s actions undermined this trust.
13. For the avoidance of doubt, I have set out Exhibits SR1, SR2 and SR3 below.
14. Exhibit SR1 - Letter to **[I/S]** the head of the Chelmsford & Essex Centre, dated 16 April 2021.

“Dear **head of the Chelmsford & Essex Centre**

I wrote to you previously on 29th October 2019, regrettably you did not do me the service of a reply, I can only assume that's because you do not recognise me as the deceased's next of kin, even though I was recognised as her primary carer.

I write today, not to request a reply, simply to supply you with material that will give you context to my relationship with the deceased and ask that you examine the paper I have submitted regarding the care she received from your department. I will allow you to draw your own conclusions as to whether that care was acceptable. I do not wish to raise any complaints, I simply wish to raise my concern that this lady did not receive an acceptable level of care and if I may, was failed.

I will set out the events dating back to 2010 when I first started caring for the deceased and very importantly the events of 2013 which I believe heavily influenced the view your staff took in 2019, on the relationship the deceased had with myself. A view that I know was incorrect and which may have possibly contributed to her premature death.

I know the truth of my relationship with Ms Breczko-Nowak and I am comfortable that I did my utmost to care for her, even under the most challenging of circumstances. I had no training and no experience of helping someone with addiction and mental health issues; I received almost zero help or guidance in to your life.

I am supplying the attached information, for a very simple reason; people deserve better. Nothing will bring my friend back, but I do want her to have a legacy, a legacy of change. It is my belief that the care Ms Breczko-Nowak received from both Brentwood and Chelmsford Mental Health unit's staff was far below the required duty of care that both the organisations and their staff are required to provide and this resulted in a level of care that was continually unacceptable. I hope that you will, not just as the head of this unit, but as a human, look at this information and implement change to improve the care that the most vulnerable so desperately require. My hope is that by reviewing my information, this will empower you to address the severe disconnect that exists between your service and that friends and families that care for these vulnerable people. I understand and have experienced personally the protocols

your organisation has and how you handle all of these aspects, but I ask the question; who are these protocols there to protect?

As I have stated I do not want any answers and I know that due to the fact the deceased did not tick a box with your department of the NHS, though she did with other departments (Article 13), you do not have to do so. I cared for this lady for 9 years of my life, when very few others did, everyone deserted her, I was one of the very few that stood by her. Yet I was not given the courtesy of a diagnosis or the decency of being treated with respect by your health service so that I could provide her with the support and assistance she needed and deserved.

I have set out the facts and my truth; you decide.

Kind regards

Stuart Ringer.”

15. Exhibit SR1 – A statement of fact which details the development and circumstances of Gosia's mental ill-health.

“Statement of Fact – 16th April 2021 - Death of Ela Breczko-Nowak

I will set out over the next pages a summary of the time I spent caring for the deceased. For your information, her name was Malgorzata Elzbieta Breczko-Nowak, she was known to different people by different abbreviations of her name, some would call her Gosia, short for Malgorzata and some would call her Ela, short for Elzbieta. She was born on 30th June 1977 in Poland. For the purpose of this letter I will call her Ela.

I first met Ela in 2001 when she was living in Spain. We had a brief relationship, though it was clear even at this point that she was deeply troubled person. I would discover at a later date what these troubles were, but at this point it was not something she would talk about, there was just a lot of volatility in her actions. We went our own separate way but remained friends; she was a very kind and caring person.

In June 2010, Ela moved in to my address at [redacted] with the purpose of house sitting, as I was due to be on an extended overseas visit. The visit was cut short and I returned after approx. 6 weeks. It was at this point that her alcohol issues became apparent. I took her to the local GP and he diagnosed that she was alcohol dependant and she was referred for help to a charity, however I can't remember their details. I had no understanding or knowledge of alcohol dependence and was therefore shocked to be told by her GP, that the fits she was suffering from, were alcohol withdrawal and that she had to drink a certain amount of alcohol per day. This was just the start of my education on addiction and it was an extremely steep one.

I sold this property in early 2011 and I paid the deposit and first month's rent on a small flat in Whitechapel for Ela. She was not in receipt of benefits and housing support; regrettably this would not last long. As soon as she started to live on her own her mental health declined, she would not open her mail, she would miss meetings with the DWP and the NHS. No rent was paid and legal proceedings were issued against her for eviction. I found her another flat in late 2011 and assisted her to move to a new address. I helped her reconnect and register with the various departments and her benefits were reinstated.

For approx. six months there was a period of calm, but slowly I could see deterioration within Ela beginning to occur. Ela descended in to a deep depression and her alcohol consumption increased dramatically. Tower Hamlets Mental Health Team were contacted and tried to be involved, but Ela would again not answer the phone or open her mail. Things were becoming out of control and I had deep concerns for Ela welfare. The mental health team in my opinion were not being proactive in there level of care. They knew she did not open her mail, they knew she would not answer her phone if she saw a withheld number, which invariably government departments use. Even though I had reached out to them several times, at no time did any of their team accept my offers to help communicate with Ela.

Due to her unwillingness to open her mail, she had again been sanctioned by the DWP for non-attendance of meetings and both benefits and housing support had been stopped. She was again on the verge of being made

homeless. This was a prospect that I was extremely uncomfortable with for obvious reasons, I also felt that she needed support and help with her communications with the mental health team. It was my belief from the behaviour she was exhibiting that she was suffering from mental health issues and I felt that if she continued to be left to her own devices her life would spiral further in to self-destructive patterns and she would become increasingly vulnerable.

We are now at approx. September 2012; I was living in Brentwood, Ela and I discussed her options, which were very limited, Tower Hamlets Council had advised they may be able to provide housing for her but she would actually have to be homeless for this conversation to start. We also discussed her coming to live with me and I offered to help her make contact with the local GP and a referral to the local mental health team. I did however put a condition on this and that was I wanted her to engage with AA or a similar organisation, which could help her with her addiction, to which she agreed.

I have detailed my correspondence with the Brentwood team, known as SEPT and her care coordinator [CC B] which frankly was woefully inadequate and instead of helping with Ela's issues, made her anxiety worse, which lead to increased alcohol abuse and greater dependency on prescription drugs. – Article 1.

On 19th April 2013, I wrote to Ela's GP, to express my concerns over her lack of medication – Article 10. I did not receive a reply to this and as far as I'm aware, the GP and SEPT did not speak directly. I also became aware that both the GP and SEPT were prescribing the same drugs, i.e. Ela was able to double medicate. This is a clear indication of not undertaking due diligence by both her GP and the team at SEPT. Neither Ela nor I received a reply to said letter. This is another example of a breach of the duty of care that healthcare organisations and their staff have to their patients. I would also be confident in suggesting that double prescribing of high risk medications from healthcare professionals is negligent practice.

Due to poor communication with [CC B], I wrote a letter of complaint to the head of SEPT, Dr Patrick Geoghegan on 10th April 2013 – Article 9. I met with Dr Geoghegan and we discussed Ela's case. During this discussion I

was informed that Ela had made a comment that I may have used physical force on her and protocol said that due to this SEPT were not able to communicate with me, hence lack of recent communication. We discussed whether this comment may have been truth or a result of medication and alcohol. It was decided that we should in the interest of Ela, restart her care and communication with myself.

It was agreed at this meeting that Ela would be assigned a new care coordinator, [care coordinator C]. Whilst communication did improve, Ela's condition did not. On 31st May 2013, I had a meeting with [care coordinator C] at which it was decided that at las the mental health team would take a greater role in looking after her. I also expressed at this meeting, my own issues with stress from not only dealing with Ela's addiction, but a lack of understanding on what to do to cope personally.

Over the following weekend, Miss Nowak was in a medicated haze and on Monday 3rd June, I called [care coordinator C] requesting that she speak to Miss Nowak's GP to find out what was going on. I also informed her that Ela had extremely black eye, a condition that Ela would not give a clear or coherent answer to where she acquired the injury, merely stating she had fallen, which was clearly not the truth. That evening Ela was so heavily medicated, that she became trapped in the bath, she had let the water out and was unable to lift herself out of the tub. I came home and found her almost passed out and had to physically lift her out; she was covered in bruises.

On the morning of Tuesday 4th June [care coordinator C] called me to explain the medication, however Miss Nowak was then in a worse condition and I explained the events of the previous evening, therefore I requested that [N/S] [care coordinator C] attended my property to see for herself Ela's condition. It is very important to note at this point, that I am informing SEPT of Ela's condition, it is me requesting their staff attend my property and assess Ela, I had nothing to hide.

[Care coordinator C] and Dr Geoghegan both came to my property and on inspection, it was agreed that a fall was clearly not how these injuries were sustained and also, due to Ela's inability to both walk or stand without assistance, she

should attend hospital. At first Ela refused, stating that she was OK, but under duress she finally agreed for an ambulance to be called.

I will be very clear at this point, I could not cope; this was breaking me as a person, looking after an addict at this point of their addiction was proving more than I could emotionally deal with, I needed intervention. I had also stated in one of our meeting, that if SEPT did not do more, I would be the next person they would be treating. I made a very, very difficult decision. I stated this to Dr Geoghegan, who replied "Well, you invited her in to your life"! an extremely unhelpful comment.

*After she was collected I contacted **Mr D** from Basildon Hospital's Alcohol Unit to inform him that Miss Nowak would soon be in A&E. I did this as he had liaised with **care coordinator C** on previous times when Ela had been hospitalised due to alcohol withdrawal. I informed him that I could no longer cope with the stress that this situation was placing me under and that after consulting with my solicitor, I was within my rights to refuse to accept Miss Nowak back to my home; this was at approx. 11.00 on 4th June 2013. He told me he would discuss the issue with SEPT.*

*At 16.45 **Mr D** called me to say that I could collect Miss Nowak as she was free to leave the hospital. I repeated that I was not in a position to allow Miss Nowak to re-enter my property, I then called **CC C** to ask why I was being asked to collect her and also state that I was not prepared to do so, she informed me that she would look in to what could be arranged.*

I returned home at approx. 19.45 and was met by two officers from Brentwood Police station and arrested on a charge of GBH! I was detained in a cell at Grays Police station for 23 hours. Despite asking both the detectives that interviewed me and writing to the Chief Constable on 27th July 2013, I have never had a clear explanation as to why I called by the hospital to collect Ela, then within hours being arrested as I was a danger to her, other than we had once been in a relationship; 10 years prior. The timeline of these phone calls in my opinion is highly relevant.

What I have never been able to ascertain is, what changed between 16.45 and 19.45? A coincidence perhaps that Ela was taken to a shelter which is

exclusively for women who have suffered domestic abuse. If SEPT had not been able to home her there, she was then their liability and I assert that SEPT undertook fraudulent behaving by misguiding Essex Police as to how Ela sustained her injuries, which is a possible perversion of justice at worst and a shameful distortion of the truth at best. The fact that someone had twisted the facts to help fit with their criteria is disgraceful.

This is of course is an assumption that I will never be able to prove, but I wish to give your office full disclosure on these events and what I believe happened. The purpose of this is for honesty and clarity, but also to give you an insight to my distrust of the local mental health organisations as they currently stand. They appear more concerned about their own appearance, than the people they are appointed to serve; the most vulnerable in society. I would like to state that Ela was categorical in stating she never made an allegation that I abused her and could not understand why I had been arrested for doing so. I did try to pursue this with Essex Police, but was given a very poor response. Article 3. What I wish to highlight from this mess, is that their false allegations lead to a much bigger problem, albeit a few years down the line. Your team took their brief from SEPT's records and judged me without knowing the facts.

Ela was placed in a shelter in Harlow, a shelter for women that were the victims of domestic abuse. This shelter had a ban on alcohol on the premises and after the discovery that she was in possession of alcohol she was evicted and placed on the street. Placing an addict in a dry facility when she would have been in a heightened state of anxiety, is yet another example where HCP's have failed in their duty of care. Knowing her history of alcohol issues I would assume that Ela should have been placed in a detox facility, which would provide her with the care she required.

After being evicted from the shelter, Ela lived for approx.2 weeks on the streets of Harlow, before she found a room in someone's home. Ela lived in various properties in the Harlow area from June 2013 until December 2016. During this time we stayed in contact and I would see her approx. every two weeks and on occasions she would come to my property for the weekend, to give her a break from her life in Harlow. During this time I supported her both emotionally and financially, as often her benefits would not be paid, for

reasons that I could never work out, but her mental health was large contributor.

Through the next 3 years, Ela's mental health went up and down, as did her drinking was under control and when visiting me in Chelmsford where I had now moved, she secured a series of cleaning jobs. We came to an arrangement where I would collect her from Harlow on a Sunday and she would stay with me throughout the working week, returning to her property by bus on Friday afternoon.

Regrettably due to complications with her housing benefit, she had fallen behind in her rent and was evicted from her address at [I/S] [I/S] with a debt of [I/S] – Article 5. She had made such great steps forward, and she was about to be made homeless, so I agreed to take her in to my home again. Due to the previous events I had my reservations, but I refused to see a friend be put on the streets again, especially when she had made such positive steps forward. She moved in to [I/S] in December 2016.

By January 2017 I really felt we had turned a corner, she had 3 jobs, money coming in and for the first time in 7 years, she had a smile on her face, was looking healthy and seemed happy. I was absent from the UK from the start of February until 15th June 2017, by this time Ela had relapsed, losing her jobs and had started drinking heavily again. It was never clear if she lost the jobs and started drinking or started drinking because she lost the jobs. I will always regret that absence and ask myself if things would have been different if I had not been so.

I attended GP sessions with her and by engaging with an organisation in Chelmsford called Open Road, she was offered an alcohol detox program, followed by a non-residential rehab with Action on Addiction in Billericay in early 2018, where she was introduced to the Duchess of Cambridge on a visit – Article 4. This proved very successful, after this I engaged a private physiologist: [I/S] to help Ela with her issues, she continued with this until approx. November 2018, but unfortunately Ela had started drink again and it appeared the sessions were becoming less and less useful. This was making things very difficult in my home and as much as I wished to support

Ela and help with her addictions, it is an incredibly difficult situation when you see someone being so self-destructive and not wishing to engage in any form of self-help. My patience broke and I asked Ela to find alternate accommodation as I could not cope. Again, my own mental health was starting to fail.

By the end of November 2018 her physical health was deteriorating alarmingly, due to not eating or drinking enough fluids and she started to be faint. At this time I called an ambulance, when they attended I asked them to inform the local mental health team that she needed help. Given my previous experience, I did this reluctantly, but it was a necessary step. But also a step I now regret.

Ela called me from Broomfield Hospital to inform me that she was being transferred to a Peter Bruff Psychiatric Unit at Colchester Hospital. She stayed at the facility for approx. 10 days and whilst she did not enjoy the experience, she appeared to be in a much calmer place when she returned to my property. Whilst visiting with her at the facility we discussed her housing and we agreed that due to what was now accruing and if a program of recovery could be put together, then my home would remain her home. Her recovery was the priority.

From the 16th December to 27 December I was absent from my property attending a 10 day meditation retreat, a Vipassana, which I had booked for many months. I was reassured by Ela that she would have regular visits from the crisis team in my absence. On returning to my home, Ela seemed in good spirits, if a little hazy due to medication, but there was no sign of alcohol intake.

During this retreat I had time to reflect on many aspects of life and I realised that even though dealing with Ela's addiction had taken its toll over the past 8 and half years, I needed to do more. Ela's life has been peppered with people turning their back on her and that I would not be one of them. When I returned home we sat and talked and I reassured her that I would keep her safe while she dealt with the current difficult period and that I would help her with both the many debts she had run up, but also a legal case that her daughter had won in Poland and was being applied for in the UK by HM Courts & Tribunals

Service under ref – [I/S] I was successful in reducing much of her debt, but the court case was live – Article 2. Both of these items were causing her a considerable amount of anxiety and she was dealing with it by simply ignoring the correspondence. There was a palpable sense of relief that I would take these worries away and she could focus on recovery and what she most wanted, finding a steady job.

Sometime in January [care co-ordinator A] attended by property to visit Ela and I spent approx. 15 minutes talking to her, in which I made it very clear that as Ela's primary carer, I needed to be kept informed of her care and medication programme; I was both disappointed and extremely distressed that on several occasions I was never included in these discussions. I was however offered an appointment for me to meet with a member of the team to discuss my own problems and issues I was experiencing due to living with an addict.

On 21st March 2019 I met with [Ms E] at the Chelmsford & Essex Centre, New Road Chelmsford – Article 6. I explained to [Ms E] that the support I needed was greater support for Ela, both in terms of her mental health, understanding her medication and care program and in applying for some form of benefits, which at this point she was not receiving. At this time Ela was in Broomfield Hospital with a suspected gall bladder issue. This was causing her added anxiety; she was in the unit for 9 days. During this period she called [care co-ordinator A] multiple times and sent her text messages, not once did [care co-ordinator A] make contact with Ela, either by text or call or have someone from the team visit Ela to calm her anxiety. She may have contacted the ward, but if this was the case, Ela was not advised by the nurses.

Ela made it clear to me that she was unhappy with [care co-ordinator A] as she was failing to communicate with her and that she wanted to request a change of coordinator, I advised that this needed to come from her, and she should request this at one of her meetings. Ela advised me during one of our discussions she felt [care co-ordinator A] was trying to coerce her into making false statements about her living arrangements. After a meeting with [I/S] [care co-ordinator A] in April, Ela wrote down what was said. She claimed to me that [care co-ordinator A] had pressured her in to incriminate me, so that she

*could have placed Ela in a refuge called Safer Places – Article 7. This strikes me as extremely unprofessional behaviour and raises the question of whether **care co-ordinator A** has breached professional codes of conduct, expected of a HCP and the NHS?*

*Given my previous treatment by Brentwood mental health team, I found this particularly alarming behaviour for two reasons. 1 – Ela was being asked to walk away from the only friend that had stood by her throughout her troubles, she had no other support system, in the UK, one friend who lived in Australia and was estranged from her remaining family. This had the potential to heighten her anxiety. 2 – The possibility of having my name again falsely tarnished. If **care co-ordinator A** had the slightest insight in to Ela's condition, she would have realised that a sense of abandonment was one of her biggest fears. She was now asking her to lose her only friend. I believe this caused Ela a great deal of instability and was a major contributing factor to her declining mental health through April and May 2019 and why she asked to be readmitted to the psychiatric unit at the end of May 2019.*

It should also be noted that through March, Ela started to ask me for an eviction notice, something that took me by surprise. When I asked her why she was doing this, she replied "if I have my own place, I will not lose you as a friend". I tried to reassure her that regardless of whatever happened, she would never lose my friendship and support. It is my assertion that this out of character behaviour was being driven by the unacceptable coercion that your team member was applying to her. Ela's so called care-coordinator was creating a level of panic that I had not seen prior. This came to a head on Friday 21st June, which I will come to.

*On 22nd May 2019 Ela was very anxious about a meeting she was having the following day with **care co-ordinator A** and Dr **[I/S]** she told me that she was going to task to be placed back in the psychiatric unit in Colchester. Over the previous 7 days, she had become more agitated, however I was still taken aback by this remark, we sat and talked about this and it was clear that she felt it was the right thing to do as she said "I just cant control my mind". At this point she was not to my knowledge drinking. I also suspected that she had stopped or at least was not taking the correct dosage of her medication. As I had not been given her medication plan, I had no way of knowing.*

On the morning of Thursday 23rd May 2019, Ela asked if I would attend the meeting, as she was unstable on her feet and also she wanted me to be in the meeting to hear what she had to say. During this meeting Ela expressed her desire to return to Peter Bruff ward, this was not immediately agreed to, in fact there was noticeable pushback, at which she expressed thoughts of suicide and when pressed replied "believe me I have enough stuff to do it", a comment that was seemingly ignored by the two HCP's present. In this meeting [care co-ordinator A] talked to me but seemed agitated at my presence and spoke to me only on occasions when she had to. She also accused me of being an enabler, due to me helping Ela with her financial position as set out in Article 2. [care co-ordinator A] made it clear that these were Ela's responsibility. Given that Ela had just voiced suicidal intent, I was staggered that your team was more interested in me helping Ela with her debt, than she was in her patient voicing suicidal thoughts. From the behaviour that [I/S] [care co-ordinator A] demonstrated in the meeting, I questioned her suitability for her role as she seemed unable to recognise the agitation Ela demonstrated throughout the meeting and was dismissive of Ela reporting her thoughts of suicide. My understanding of patient care, especially within the mental health stream, is that holistic and compassionate care should be provided to both the patient and significant care providers and this was not what occurred in this meeting.

On 25th May 2019 Ela was picked up from my property by ambulance and taken to the Peter Bruff ward, Colchester. She would call me most days and let me know how she was feeling and informed me that they would be arranging for her to have housing when she left. I again reassured her that this did not need to be her priority. I visited her there and we spoke about this issue as I could not understand why this become a preoccupation for her. It appeared to me that she was being pressured to move from my property, even though she was not in receipt of public funds, therefore not a realistic prospect.

On 4th June 2019 I was contacted by [I/S] a discharge coordinator at Peter Bruff ward, who asked if I could provide a letter stating that I wanted Ela to vacate my property. I was extremely taken aback by this request, as this was not what I was expressing, however I was informed that Ela would

need this letter if she was to be able to be rehoused. We discussed the contents of the letter, but only under duress did I agree to write this. I raised two concerns, firstly why was housing being sort when Ela was not in receipt of public funds and who was pushing this agenda. I did not get a clear answer to these questions. I was contacted on 5th June 2019 by Chelmsford Council to discuss the issue and I told them I was in no hurry for Ela to move out, which I was informed was good, because Ela was not eligible for public funds, therefore Chelmsford Council would not be housing her. It is my assumption that someone in your service was pushing this agenda to rehouse Ela, but they would have known that she was not in receipt of public funds, so would be refused housing. Someone needs to explain to you why that agenda was pursued, as it caused Ela a great deal of anxiety and confusion, something that I would be the last thing for someone in her condition. I cannot understand why members of your service would pursue a course of action for Ela if it is clear that there was no way that the outcome they are pursuing could be reached. I would assert that this action is highly unethical.

Ela was released from Peter Bruff on 5th June 2019 after a short check on her gallbladder in Broomfield Hospital. I was not contacted or informed this would be happening, I was simply called by Ela to say that she was at home. I was given no diagnosis, guidance or medication plan by Peter Bruff or Chelmsford Mental Health team. I was her primary carer and Ela's care coordinator did not include me in her care and medication program, this is yet another failure of duty of care and I believe the most serious throughout this sorry story.

Through June Ela actively engaged in AA and at her request, I attended some of these meetings. She seemed to be genuinely engaged with this process, which before she had resisted, she did not like the references to God, it related too much to her Catholic upbringing. At one of these meeting she proudly picked up a badge for being sober for a month.

Article 11 – is my letter to care co-ordinator A dated 7th June 2019, to which she responded. There are also letters to Ms E none of which were replied to. I'm sure you will state "protocol", but at this point, I would propose that I have demonstrated clearly that your protocols hurt people, are ineffective and do not ensure that patients and their carers receive the best possible care. I would recommend that your protocols require urgent review,

evaluation and rewriting. Ela was not protected by your system or protocols at several points during the care she received from your team. she was placed in danger by members of your team who acted unprofessionally and were negligent in the care and advice they provided to her. I was her primary carer given and she prescribed large amounts of addictive and possibly fatal drugs, yet I was given no guidance of dosages.

On 16th June 2019, Ela had a home visit from one of your support works, I'm afraid I do not have a record of her name. I raised my concerns about the lack of inclusiveness and my concerns about Ela's ability to coordinate her medication. Ela was not able to remember what drugs were taken when, if she forgot she could easily double or trebled dose. I still received no contact from your department.

On Friday 21st June 2019, Ela called me in the afternoon in what can only be describes as a state of hysteria. She had just been at the Job Centre Plus and had been told that she had been refused benefits. Her conversation was fixated on the fact that if she could not get benefits, she could not be moved to another property. Again I tried to calm her, again repeating that this was not a priority, but she kept repeating "CC A wants me to move, CC A wants me to move". I believe your team members coercion had made Ela fixate on moving home, however care co-ordinator A action has led to a state of heightened anxiety, not only was Ela being told by a health care professional that she needed to lose her primary carer, she was simultaneously being told by DWP that she could not have any funding for such a move. Your team member led her to an impossible place of confusion and fear. An action that is simply reprehensible and completely against all I would hope that a mental health unit stand for. And given Ela's propensity to go to her safe place of alcohol, incredibly dangerous given the amount of medication she had access to at this time.

Ela had one other friend apart from me, Melanie Ferguson. Ms Ferguson met Ela in 2004 while working in the UK as a nurse; she is a native of Australia and is a practicing nurse there. Her qualification and experience are detailed in Article 8. Ms Ferguson was visiting the UK and was due to spend a week in Chelmsford from Sunday 23rd June 2019. Ela was excited to see her fiend and they had planned to spend the week catching up and having some fun. I

could however detect that Ela was becoming anxious about Ms Ferguson's arrival, much had changed in her life since they had last seen each other in 2008.

I returned home on the afternoon of Saturday 22nd June 2019 and found that Ela was intoxicated with alcohol. She had been clear for 6 weeks but had succumbed to her demons. I attempted to talk to her as to why she had done so, but I could not get a coherent answer.

I left early for work morning on the morning of Sunday 23rd June, Ela was sleeping, so I left her a note asking her to stay sober, remind her that a good friend was coming to see her, that there was nothing to fear, or hide, Melanie knew all about her problems and was coming because she cared. She called me at approx. 11am and promised that she would stay away from drink. Ms Ferguson arrived at my property that afternoon, her account of this and the next 3 days is contained in – Article 8. I have Ms Ferguson's consent to release her account – Article 12. Article 12 also give Ms Ferguson's opinion on the relationship between Ela and I.

I returned home at approx. 7:30pm on 26th June 2019 and Ms Ferguson outlines the day's events. Ela was curled up on the sofa and I sat next to her and asked why she had drunk that day. She replied "it's the only thing that makes it stop"! I asked makes what stop? "I don't know"! They were the last words she said to me. Ms Ferguson and I went out for approx. an hour and a half for some food, on returning Ela was not in the living room, so I checked that she was in bed, she was.

At 8am on 27th June 2019, I took Ela a cup of tea, as I walked in to her room I noticed that her arm, which was all I could see at the time, looked badly bruised. I instantly recalled the injuries she suffered in 2013 as it looked like bruising, as I placed the cup by her bed I looked at her face. I will never forget that image, I knew instantly that she was dead. She looked like she was asleep, I felt her skin and she was cold. I called Ms Ferguson and as a nurse she too knew that not only was she dead, but had been so for some hours.

At first it was believed that Ela had taken her own life, it would later be discovered she died of Alcoholic Fatty Liver Disease. Due to the possibility of

suicide and an inquest, the Coroner asked both Ms Ferguson and I to complete a Statement of Fact covering the days and weeks leading up to Ela's death. It is from the statement that I have pulled all of the facts above, these are not faint memories, but accurate accounts from the time. Ms Ferguson's account was written on 30th June 2019 and each page is dated and signed and I have her permission to provide these to you.

Ela's death was deemed as natural causes, therefore an inquest was not held. At the time, finding out that Ela had not taken her own life felt like a relief. The thought of her taking her own life was crushing. But she did take her own life, she overdosed on alcohol. Technically of course its not an overdose, but if you take too much of a substance and your body is not able to cope, it's an overdose and it's an exercise in semantics to argue otherwise.

So an inquest was not called and both our reports remained private. Whilst I am still relieved that Ela did not take her own life, I deeply regret that there has not been an inquest. A n inquest would have had the power to question the actions of your staff and examine your department's conduct. Ms Ferguson's account of that final day and her account of Ela's meeting with your staff tell the most important details of the treatment Ela received. I will not comment further on her words, I believe they are damning enough in themselves.

I have written the above and supplied the attached evidence so that you can ask yourself if the teams at both SEPT and your own fulfilled the required duty of care between a health service and the patient who engages them for care and gave Ela the best treatment that was available. To whether you acted in her best interest and ask yourselves whether the protocols you have in place, truly safe guard the most vulnerable in our society.

I know my truth, I know what I did or did not do and I am very comfortable that I did the utmost to protect, care for and create a safe space for Ela to try to recover. I know I never abused her, in anyway. I know that the care and service she received from the NHS was at best questionable and at worst life endangering.

I will assert that your department and particularly [care co-ordinator A] were negligent and instead of helping Ela with her issues, made them worse and potentially contributed to her premature death.

I stated at the start of this letter that I do not want to raise an official complaint. I am not doing this to clear my name, frankly I couldn't care less what you think of me, my conscience is clear. I will leave it to you as to what happens next. This may all end up the bin, as these are the words of an "abuser". What I hope is that you will as a human, look at this case and change how you do things, change your protocols and look at the person who is caring, not as someone to be vilified, but someone who is doing their best to cope with a mental health sufferer and an addict and on a daily basis trying their best to help that individual.

I am aware that mental health is the ignored aspect of our health system and far too often it is viewed as something that you will just get over. This is an excerpt from the eulogy I read at Ela's funeral – "For the past 9 years Ela has fought a battle against a disease that society does little to recognise, let alone tackle. If what she suffered from was a physical sickness, there would be a public outcry as to why so little is done to help those who suffer. Depression, anxiety, addiction; it's all just brushed aside. We have no publicly funded addiction service in this country, yet we spend millions dealing with its effects."

Please be part of the solution, not part of the problem. I thank you for taking the time to read this letter.

I will now give you some background on Ela's life, details that I took her years to entrust me with. She was born in Poland on 30th June 1977, she had a happy enough childhood, until [I/S]

a period where she began to experience emotional, physical and sexual abuse

[I/S]

[I/S]

[I/S]

Her Grandfather

was a tough old man, a man with one leg and a survivor of Auschwitz. She found comfort and piece with him, but regrettably this did not last long and he passed away when she was 16 years old. She bounced around other family members for a few years, until she fell pregnant at 19, which suited the family and she was quickly married off.

The abuse impacted Ela and her family

[I/S]

She once said to me that she did not deserve to be happy, it was one of the saddest things I have ever heard anyone say.

Ela was never able to bond with her daughter and this would be a patent though her life; being rejected and rejection of others. She was unable to trust people and she could not understand the concept of kindness from strangers or being open about problems, she always believed other would see this as weakness and exploit that knowledge, yet she could be incredibly kind.

Ela never trusted men; in fact I would say she hatted them. The abuse she suffered [I/S] scared her deeply. There were only two men that she trusted in her life; her grandfather and myself. She would often say that I remaindered her of him, because I moaned a lot, but just like her grandpa, she did trusted me and I never abused that trust.

Kind regards

Stuart Ringer.”

16. Exhibit SR2 – Letter to **care co-ordinator A**, Mid Essex Community Recovery Service, dated 7th June 2019. This letter details me expressing my concern that I have not received any form of communication after Gosia's release from Peter Bruff Ward on 5th June 2019.

“Dear **care co-ordinator A**

This Wednesday 5th June, Ela was released from the psychiatric unit in Colchester and back to my property, after a brief visit to Broomfield Hospital for her gallbladder issue.

I have had no communication from any department to convey why she was released, what were the findings or what is the plan going forward. I am deeply concerned at this lack of information, I have asked Ela for information, however and quite naturally given that she is on medication, she is confused and unclear of the current standing.

I understand there are protocols in place as I am not related or her partner, however she does not live in my property, she has no access to public funds currently, so I cover all her living costs, as well as doing my best as an untrained person, to offer support. This support takes its toll on me at every level; the hardest thing for me to deal with is a lack of information or knowledge of a plan for Ela going forward.

As I have just expressed, I understand you as an organisation will have your protocols, however I don't think it unreasonable for me to be included in solutions for Ela's future. I would appreciate an open line of communication and perhaps a meeting to discuss how I can better help in this.

Kind regards

Stuart Ringer.

17. Exhibit SR3 – Gosia's handwritten note of meeting with her care co-ordinator

Care co-ordinator A on 4th October 2019.

*"Meeting with **CC A** 4.10.19*

We talked about me moving to safer placed, I explain it would be difficult without eviction note or claiming that I'm being physically, verbally or mentally abused at my current address. If I claimed any of the above, I would be immediately be given alternative accommodation but it would also mean that Stuart will have a criminal record.

To that she answer "so what" and suggest that I should cut all the ties with Stuart asap in order to move on."

Statement of Truth

I believe the content of this statement to be true.

SIGNED

[I/S]

MR STUART RINGER

Dated

30/7/25

