WITNESS STATEMENT OF ANASTASIJA FULLER PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **Ms Anastasija Fuller** (**DOB:** [I/S], of [I/S] [I/S]) am the mother of Milan Radovanovic (born on 26th October 1992; died on 25th July 2018.)

2. I am making this statement from a combination of own my own memory of events, knowledge, belief and having access based on my memory of events, from having seen my late son's records / other disclosure and the evidence placed before the inquest (into my son's death), which was held on 29th November 2018.

Diagnosis

First development of Milan's mental health difficulties

3. Milan's first difficulties appeared at the time of his first and second hospitalisation from his total colectomy laparoscopic surgery, in March 2015 and later in 2015.

4. On 21st March 2015, Milan was admitted to Broomfield Hospital Accident & Emergency, with uncontrollable rectal bleeding. Following his admission, Milan was subsequently diagnosed with Ulcerative Colitis-Toxic Megacolon and thereafter, put on 9 days of IV antibiotics treatment, which did not help him.

5. Milan's gastroenterologist, Dr [I/S] raised alarm that his condition was getting worse and was also becoming life threatening. The colorectal surgeon Dr [I/S] [I/S] talked to Milan about the severity of the situation and that the only way to save his life would be a total colectomy and a stoma bag fit. Milan was very concerned and initially didn't accept to be operated on. The senior surgeon Dr [I/S] managed to persuade him, explaining about the positives of the laparoscopic surgery, assured him that it will cure the inflammation, and that in a few months' time, the stoma would be replaced with a J-pouch which would be created and fitted inside his abdomen to take over the role of his colon. Milan welcomed this news and agreed to the operation.

6. On 2nd April 2015, the surgery was carried out. After the surgery, over the several days that ensued, Milan went through a very unpleasant and undignified process of rectal recovery procedure. He felt awful then about himself, ashamed and embarrassed, and was relieved after this stage of recovery was over.

7. I first noticed problems with Milan's mental state soon after his return home from his laparoscopic surgery. In my opinion (based on conversations with my close friend Dr [I/S] who was a medical doctor gastroenterologist based in Belgrade, and who new Milan since Milan's childhood) Milan needed a good physical post operation long term recovery. However, despite the requirement for rest, Milan insisted that he needed to return to his normal life routine very quickly, including diet, his exercise regime, his demanding post-graduate studies, socialising with friends and other things. I felt everything Milan was doing, was way too quickly and too soon given what he had been through physically and emotionally.

8. No surgeons from Broomfield hospital, gave Milan any explicit instructions for his post operation recovery, and just told him to take care.

9. What was clear to me at that time, was that Milan was in denial of his illness. All he wanted was to go back to his normal life. Any physical pain and discomfort that he was going through at that time he ignored.

10. Three weeks after his surgery, Milan went for a few days trip to Prague with his good friends, after which he got back very exhausted and ended up in hospital with an infection, which was treated with antibiotics, before being discharged after few days. However, from then onwards, Milan never recovered in full. The only person of medical profession background close to Milan at that time, was [I/S], who worked for Broomfield hospital, Mid and South Essex NHS Foundation Trust as his stoma nurse and who would see him once a week for a stoma check-up. I tried to share my concerns with her about the physical care of stoma and his state of mind and what needed to be done about his deteriorating physical and mental health. Her response to me at the time was that Milan would be fine and that I should definitely not add any pressure on him and also to just leave him to deal with what he was experiencing in his own way.

Milan's first contact with mental health services

11. In December 2017, Milan was sadly dismissed from his job at **[I/S]** (an Estate agent and property consultant company), as he was told by his line manager that he 'did not fit in and was advised by his line manager to consider taking counselling'.

12. Milan's first contact with mental health services was in 2018, three years after his first operation on his intestines in 2015. On the morning of the 1st January 2018, at our family home, Milan stopped eating, telling us that he was in pain in his abdomen and that in order to heal himself, the only way was to stop eating. I think this was his genuine answer at that time. He was angry when we attempted to talk to him and persuade him to take food and drink.

13. On 10th January 2018, nine days after this incident, Milan was admitted to Bromfield hospital Accident and Emergency surgical ward, where he was fed through tubes. Milan's stoma nurse **Nurse A** had talked to him and asked him if he wanted to die. To this, Milan replied that he did not want to die. After **Nrs A** had left, Milan became very upset and carried on refusing to eat and drink.

14. On 11th January 2018, Milan was referred by the surgical ward to AAS.

15. On 12th January 2018, Milan for the first time Milan was visited by NHS psychiatrist, **[I/S]** **Dr A** on Broomfield surgical ward. I was not present during this visit.

16. On 18th January 2018, Milan was reviewed by psychiatrist, **Dr A**, who recommended based upon Milan's presentation, that he be sectioned under section 2 of the mental health act (MHA). Thereafter, an AMP referral was made. A mental capacity assessment of Milan was then conducted with the outcome being that Milan was deemed not to have capacity.

17. On 19th January 2018, Milan was seen by AMP with the initials **AMP A, who was not able** to detain him due to Milan being in a state of delirium, according to the root cause analysis report. Milan was advised that he should be treated under the MCA 2005 Best interest Decision due to treatment for his physical health and was advised that that this may need the decision make need to be directed to the court of protection.

18. On 25th January 2018, Milan was again assessed by psychiatrist, Dr A on the Heybridge ward, where it is noted that Milan had agreed to accept anti-depressant treatment in liquid form but refused electroconvulsive therapy (ECT).

19. On 30th January 2018, Milan was assessed by psychiatrist Dr A again on the Heybridge ward, where it was documented that Milan had limited dietary intake, started to accept his medication, but had continued to refuse ECT. It was also documented that nasogastric feeding to be considered.

20. On 2nd February 2018, psychiatrist Dr A assessed Milan and recorded that Milan had refused oral intake of fluid and food and therefore, was place on IV fluid and liquid as a replacement. Dr A also noted that Milan was taking liquid anti-depressant but continued to refuse ECT treatment.

21. On 6th February 2018, Milan was once more assessed by psychiatrist, Dr A, who remarked that Milan had been refusing his medications and placed on IV fluid over the preceding two days. The root cause analysis reports, notes that there was *"…no insight section 2 recommendation made and referral made to AMP service"*, with Milan *"…seen by* AMP B *and detained under the section 2 MHA."* The psychiatrist was Dr B [I/S] who I met once on the ward and who told me that there was no space for Milan at the neighbouring psychiatric ward and in line with that few weeks later Milan was transferred to Basildon Hospital.

22. On 7th February 2018, Milan was transferred to Basildon University Hospital. Firstly, he was taken to Thorpe Ward (Rapid Assessment Interface & Discharge Service / RAID) where he was not admitted in the end but placed on a general ward, known as William Harvey Ward and he waited there to be assessed.

23. While on William Harvey ward, first he was placed in a single bedroom with 24 hours watch. At that time, he was visited once, on my personal invitation, by a psychiatrist [I/S] Dr C, based in London and working for NHS then, originally from Serbia, whose contact was passed on to me by a mutual friend from Belgrade. Dr C accepted my invitation and had a long chat with Milan (in Serbian language). Immediately after that Milan started looking a little bit brighter and less depressed, and same day started drinking calory drinks. Dr C had a chat with me afterwards. She was asking me about details about Milan's childhood, a move to UK from Serbia and any traumas he might went through as a child. She let me briefly known that the age of 7 could be a

psychologically significant age for growing up. At the end of our meeting Dr C assured me that there will be an assessment, and a care plan provided for Milan by our designated regional mental care authority. However, after few days, after this little improvement that I was trying to highlight to his then doctors, Milan was moved to a Edith Cavel general ward.

24. On 8th February 2018, as medics at Thorpe ward were concerned about Milan's medical state, therefore, he was referred to the Rapid Assessment Interface and Discharge team (RAID), which I understand is a mental health service that provides support within a general hospital setting, focusing on patients with both physical and mental health needs. On the same day, Milan was transferred to the Edith Cavell Ward in Basildon General hospital, still under section 2 of the MHA. It is noted on page 43 of the "all documents within 'list of attached documents index'" that Milan was *admitted "…for decreased eating and drinking associated with severe Depression"* and that he was *"…under the joint care with Psych and Gastroenterology team…".* It is also noted on page 51 of the same document that Milan was *"…clearly very depressed"* and had *"…expressed suicide ideation to MH doctors…".* To note that these notes became available to me only after Milan's death.

25. On 15th February 2018, I emailed Mr [I/S], who was based at St Mark's hospital who knew Milan well, being his primary surgeon and doctor for over 2 years seeking for more help while explaining that we had *"…noticed that Milan has been depressed over a number of months, and also began to start eating less than usual."* I explained that Milan's *"…depression led to him losing his job mid-December"* and that he had *"…stopped eating all together on 1st January this year"* and had told us *that "…he felt very bad about himself and that there was nothing in his life left for him to look forward to."* Additionally, I explained that Milan had *"…continued to refuse both food and liquid by mouth"* and had *"…occasional visits by a psychiatrist from Basildon Hospital mental health team".* I also expressed that we were *"extremely concerned about Milan's life"* and asked what could be done to help Milan in either in St Mark's hospital or otherwise.

26. On 22nd February 2018, a referral on behalf of Milan was made by **AMP B** to the specialist mental health team (SMHT).

27. On 23rd February 2018, Milan was placed under Section 3 Mental Health act. It was explained to me that the reason they sectioned him, was to prevent his further physical

deterioration by way of being fed and watered and administered with his medication for his inflammatory disease.

28. While in Basildon Hospital on Edith Cavell Ward, it was explained to me and to Milan by his psychiatric team that the way to help with Milan's depression was to their opinion the best through electro-convulsive therapy (ECT). Both Milan and I were concerned, especially Milan, but in the end he agreed to that. Before it started, it took approximately 4-5 weeks for the psychiatric team and medical team together to sign all necessary documents and papers. It started on the 7th April 2018. The psychiatric team comprised Dr [I/S] whom I never met, Dr D and the nurse [I/S] [I/S]. I think that Dr D was trying very hard to help Milan and that the team really cared for him.

29. Before ECT started Milan complained about the pain in his intestines, looked very tired, continued to lose weight and generally looked very unwell. At that time, he tried to escape from the ward. After that he was under a dedicated 24 hr watch.

30. When ECT started he started having headaches. His natural father (who lives in Serbia) arrived at that time to visit Milan. Milan expressed he was not happy about it and asked him to leave him. At one moment, while we were in the café together, he threatened his dad and tried physically to attack him which was quickly resolved by psychiatric and security staff.

31. Finally, after eight ECT sessions Milan started to feel much better which was absolutely fantastic. Then he began to work on his 'Personal care and recovery plan'. Unfortunately, all the good work was completely diminished shortly afterwards by a perforation of his intestines, which was caused after he started eating food by mouth. Basildon Hospital surgeons assessed him and were reluctant to open him up and to perform operation being scared whether Milan would survive it. A decision was made Milan to be urgently transfer to St Mark's Hospital, a specialist bowel hospital in Harrow, on 20th April 2018.

32. I have no knowledge if and when Milan was informed about a mental health diagnosis. I was informed only after asking questions from doctors on Edith Cavell ward, that Milan suffered from Severe Depression. Later on, I have read through the report / letter dated 20th April 2018, addressed to St Mark's before Milan's transfer to there, and signed by a Basildon surgeon Dr E, noting a psychiatric diagnosis as

'decreased eating and drinking associated with severe Depression'. I also note that having read the root cause analysis report, that Milan whilst on Thorpe Ward / RAID in Basildon hospital, was diagnosed with *"…Mixed Anxiety and Depressive Disorder",* albeit, I am unsure when exactly he was diagnosed with this, but based upon the RCI report, it appears that he was diagnosed in and/or around 6th February 2018. In addition, and to my knowledge, Milan was diagnosed by **Dr D**, Locum MHU.

Assessments

Mental health assessments

33. About a month after Milan was transferred to Basildon Mental Health Unit ('Basildon'), and subsequently to Basildon General Hospital, he was also assessed by the psychiatric RAID (Rapid Assessment, Interface and Discharge) team while he was an inpatient there. This RAID team review took place during his stay at Basildon General Hospital.

34. Beyond this, I don't have detailed records or formal documentation of the assessments, but my understanding from what I was told by hospital staff is that these assessments were part of the process leading to, and following, his mental health admission and detention under Section 3. As far as I am aware, these were the key mental health assessments Milan underwent during that period, connected to his inpatient care and treatment, and that some form of psychiatric assessment was taken in January 2018 at the time when Milan stopped eating and drinking while being inpatient in Broomfield Hospital.

35. I would kindly request that the inquiry team request that EPUT gather and provide the assessments that lead to Milan's mental health admission for inpatient care and treatment, so that I can have a better understanding as to how the same was determined.

Failures / opportunities to assess Milan for mental health concerns

36. On several instances, I strongly felt that Milan needed psychiatric help and I made request for psychiatric and psychological help for Milan.

37. Firstly, in May 2015, when it became obvious to me that Milan was in denial about his illness having difficulties to accept his condition and to live with it. I discussed the problem of his stoma, with nurse Nurse A at Broomfield hospital. Nrs A then referred Milan to the community ostomists' group which he attended a meeting with only once, with no success he told me as he did not like it. There was no referral to psychiatrist then / mental health assessment, when it was appropriate to do so. I again in 2016 discussed with Nurse A psychiatric assessment for Milan, again with no referral. Milan himself refused the idea suggested by me that he needed help about his mental health at that time.

38. Later, while at St Mark's Hospital Harrow where Milan went through a number of major operations, we were requesting some form of mental health help but were informed that that this help would need to come from Essex NHS and not them. Additionally, while at St Marks, we were informed that a psychiatrist would pay Milan a visit which never happened.

39. In 2016 and 2017 when Milan's mental state clearly deteriorated, I requested St Mark's attention about Milan's mental state, specifically with surgeon Dr [I/S] and they advised that we should urgently contact our local GP (Blackwater Medical Centre), Dr [I/S], which we did but no referral was even made then. Furthermore, in autumn and winter 2017, when Milan became severely depressed and turning into a recluse, the GP's response was that he would need to sort his problems out himself.

40. Finally in 2018 things deteriorated so much that he was hospitalised as a mentally ill patient.

<u>Observations, comments or concerns regarding the quality, adequacy, process or outcome of assessments</u>

41. As I have already mentioned, I knew very little about the assessment Milan underwent, but my understanding was that the Broomfield psychiatrist was determined not to admit Milan at Broomfield hospital but to pass Milan to other hospital, being a complicated case.

Admission

Circumstances that led to Milan's mental health inpatient stay February 2018

42. Milan only had one mental health inpatient stay, which firstly occurred on 7th February 2018.

43. The circumstances that led to his mental health inpatient stay are as follows.

44. On 9th January 2018, Milan was admitted first to A&E Broomfield Hospital when he stopped eating and drinking. There as I have mentioned in my statement, he was initially placed under Section 2 of the Mental Health Act (MHA), before it was changes to Section 3 of the MHA, in order to enable him to be fed and administered with medication for his acute inflammatory disease. After a few weeks Milan was supposed to be admitted to Basildon Hospital/RAID/Thorpe Ward (psychiatric ward), but was placed in the general ward, due to Milan's need for medical care by surgeons and gastroenterologists.

45. I understand the decision to admit Milan as an inpatient, under both section 2 and section 3 of the MHA, was made by Broomfield Hospital psychiatrist, **Dr S** in agreement with someone at Basildon Hospital and coordinated by a social worker.

46. The decision to admit Milan as an inpatient, I understand was taken at the end of January 2018. But he was actually initially admitted to Basildon hospital on 7th February 2018.

47. From my recollection, Milan was planned to be admitted to Basildon Hospital, Thorpe Ward, which is a psychiatric ward, but this plan was changed. Therefore, he was firstly admitted to one of Basildon general wards (that I cannot recall the name) where he spent approximately a week or so.

48. Milan in fact felt less tense while staying at Basildon hospital, on William Harvey Ward. At that time, he was visited once, on my invitation by a psychiatrist **Dr C** from London, originally from Serbia, whose contact was passed on to me a mutual friend from Belgrade. **Dr C** had a long chat with Milan there and after that Milan immediately felt brighter and less depressed. **Dr C** then had a chat with me

afterwards. Dr C asked questions about Milan's childhood, his past and traumas he went through as a child while moving to UK.

49. Dr C assured me that psychiatric care would be provided for Milan by NHS including an assessment, a care plan with detailed medication and any other treatment, and that Milan would receive a good care by a local psychiatric team.

50. After few days Milan was moved to Edith Cavel Ward. There he was surrounded by elderly patients who suffered from severe psychiatric and other medical illnesses. Later on, when Milan's treatment had started, he was taken in a wheelchair to neighbouring Thrope Ward for ECT sessions. During his stay at the Edith Cavel Ward, the atmosphere was difficult, however I recall the staff showed big commitments and hard work and care for patients there.

51. Milan stayed in Basildon hospital as an inpatient from 7th February 2018 until 20th April 2018.

Development of Milan's mental health, and/or physical health and/or demeanour whilst an inpatient

52. Milan went through ups and downs while in Basildon. The first period was very difficult, as he was dehydrated and malnourished after not eating and drinking for weeks. He was physically very thin and looked very depressed. There was a day I recall, when he lost sense of reality and at that point he tried to escape from the ward and hid himself in a small staff room in a different ward. From then onwards he was placed under continuous 24-hour watch. That was terribly sad. In order to help him to talk to someone as he did not receive any talking therapy, I tried and arranged a private visit by a psychotherapist ([I/S]) that did not help Milan to feel any better.

53. Staff at Edith Cavell ward and RAID did not have anything against me seeking assistance for Milan by privately arranging talking therapy but equally did not want to contribute. Finally, after several weeks of waiting, the team in charge completed the paperwork and Milan had started with ECT sessions. Throughout the process he suffered some headaches and mood swings. He even attacked his natural father in the hospital café, but luckily the carer and the guard seized him and prevented any injury.

54. After 8 sessions of ECT, the outcome was that Milan suddenly started to look and feel so much better. That was at the beginning of April 2018. I recall visiting Milan on 20th April 2018, prior to his discharge. When I arrived to visit him on that day, all of a sudden there was Milan was smiling at me, looking like his normal himself.

My observations about the admission process

55. My impression was that all participants in the admission process were unsure and did not really know what to do with Milan, having a complex problem including severe physical and mental illness. The social worker (involved directly in Milan's transfer from Broomfield to Basildon) was generally the most helpful participant there, clearly understanding Milan's needs at that time.

Occasions where we asked a healthcare professional / to admit Milan or to consider

56. We as parents and Milan, never requested for him to be admitted to a psychiatric ward. However, it is important to note, that in January 2018, after Milan's admission to Broomfield hospital and being sectioned, and that nothing had in fact been done to help Milan feel better, we did make enquiries with Springfield Hospital and mental hospitals across Uk (Priory Hospital branches across the country).

57. Everyone we managed talk to on the phone considered Milan as a very complicated case and that they would not be able to help him due to the severity of his inflammatory bowel disease and therefore, mental care would be only possible for him once his inflammatory bowel disease had been resolved first. We were then advised to contact these mental health hospitals, once Milan has improved physically.

58. It was our observation in relation to the decision not to admit Milan, that it was tragic that nobody showed any will or had any idea how to help to young Milan who was suffering so much.

59. We as a family looked to organise private psychotherapy sessions ([I/S], [I/S]).

My observations when Milan was under section / decision and/or aspects of the process

60. In my opinion, it took a terribly long time for Milan's ECT to begin. During the time that his ECT was delayed, he deteriorated further both mentally and psychically.

Ward Environment

61. As I have described above, the Edith Cavell Ward at Basildon Hospital general ward was not a very pleasant ward to be in. This was especially not the case for Milan who could have benefited a lot simply just from being in a pleasant and positive environment, which would have helped him bring good feelings and to be less tense and upset.

62. The neighbouring patients in Milan's ward were elderly, seriously sick and mentally very sick people and they were virtually not possible to communicate with. On the other hand, there were medical and psychiatric staff who were working hard in order to help Milan. The 24-hour watch carers varied in their attitude, from nice, friendly and experienced, to cold and mechanical.

63. When Milan was under the care of the RAID team during ECT sessions done, he was telling me that it was fine there, and everyone was pleasant and friendly willing to help him to feel better while carrying out ECT. Milan's ECT was done under anaesthetic.

64. ECT treatment proved to be successful in Milan's case after 8 treatments. On the day I came in to visit him following his last treatment, I saw him with a clear look in his eyes; and his smile was like how he would smile in old days. It was truly amazing, and I wished so much that this positive change inside him would have stayed forever.

65. In my opinion, the Edith Cavell Ward was not the best suited place for Milan to be in, as it was lacking in space, relaxation areas, greenery and peace and quiet. The outdoor environment was grim, untidy and uninviting. Additionally, there were no activities to keep him occupied at the Edith Cavell Ward. I, however, don't have any knowledge as to what was available at Thorpe Ward or if it was offered to Milan. But the fact was that Milan had to be placed at Edith Cavell, as he needed medical help all the time. The previous ward William Harvey Ward where Milan stayed first had much better and positive atmosphere and Milan felt less depressed and calmer there even without ECT

sessions. Once he was moved to Edith Cavel ward, his mood immediately went down. I was not given an explanation, as to why he had to be placed at Edith Cavell Ward.

66. I would say however, that whilst an inpatient, Milan's basic needs were fulfilled.

67. I recall that Milan was taken to Thorpe ward for ECT treatment, once or twice a week, otherwise he stayed in his hospital bed. Throughout the day he would have medical check-ups, blood tests and be taken off the ward for scans. Taken out with his carer in a wheelchair by a carer or by family for a little wander. Daily visits by myself and family when we would go to the café together or just sitting and chatting if he wanted to.

68. Whilst, I have issues with the ward environment, I do believe that Milan's dignity was respected, when he was an inpatient. Staff were dealing with Milan's issues discretely while protecting privacy for all patients.

Staffing Arrangements, Training and Support

69. Edith Cavell was a general ward where Milan was staying, and I did not have any concerns there about the staff, training, or their ability. I did not have access to Thorpe Ward as Milan was spending short period of times there for his ECT. He did not tell me about any of his concerns.

Care Management and Plans

70. Milan was involved directly in his 'Personal Care and Recovery Plan' (titled My Care, My Recovery) but for a very short period of time. Once he was out of depression he started working on this plan with joy and which he showed to me and wanted me to get involved in it. Milan was very happy to start working out, as I think it made him look forward to a better future and hopes that he will have a real life out of hospital. This stage lasted unfortunately very short period of time.

71. I do consider that the level of engagement with Milan about decisions and plans in relation to his care and treatment was appropriate, with reference to his Personal Care and Recovery Plan. But I do not know how much he was involved into plans for his treatment as we have never seen the final care plan for Milan as an adopted document. Therefore, I would request that the inquiry team obtain from EPUT all care plans that were made for Milan.

72. In addition to the above, I was not aware of any other medically related plans being made about Milan's care after leaving Basildon hospital (Thorpe ward). I was only ever made aware of his own draft Personal Care and Recovery Plan.

73. If I could decide what could be done differently, I would have requested at the very early stage that the EPUT psychiatric team would have engaged with Milan and have produced, as early as possible a realistic and thoughtful care plan for him, which would be an integral part of a package created in order to motivate him to carry on living which he needed so desperately.

Treatment

Treatment(s) Milan was offered, at the time of diagnosis; post-mortem report

74. Milan was offered ECT (electro-convulsive therapy) by the RAID psychiatric team at Basildon Hospital. Milan's ECT was carried out at Thrope Ward. Milan did undergo ECT treatment from mid-February 2018 until mid-March. I recall that Milan received 8 treatments of ECT.

75. Following Milan's 8 sessions of ECT treatment, there appeared clear positive changes in his mental health. My son looked happy again after a very long time. He had a bright look in his is eyes and he smiled. He was looking at me on that first day like being woken up after a bad dream and was smiling at me with a little surprise in his eyes. He wanted to show me his plan for the future and to share his thoughts about it with me. He looked positive about his future. It was just so great for me to see him happy again. Words cannot exactly explain how happy I was then seeing him being fine. Unfortunately, this stage lasted for a short time, maybe just a day, as he became physically unwell shortly after that, being put on a normal 'food to mouth' diet.

76. While he was staying in both in Broomfield Hospital and St Mark's Hospital, Harrow, doctors / clinicians were focused on his physical health and completely ignored his mental health. Therefore, I feel that decisions made surrounding treatment at both hospitals were inappropriate.

77. I would add however, that whilst Milan was at Basildon hospital (Thorpe Ward), decisions regarding treatment for his mental health were made appropriately, albeit there were severe delays and it took a long time i.e. a number of weeks, for him to receive the appropriate treatment.

78. During each hospitalisation for treating Milan's inflammatory bowel disease, from his first diagnosis in 2015, until the end of 2017 (Broomfield Hospital in Essex and St Mark's in Harrow) Milan had never undergone any psychological or psychiatric assessment and any mental health care whatsoever. In January 2018, he had to be sectioned under Section 3 of the Mental Health Act immediately, but treatment for his mental illness started much later.

79. To my knowledge, the only therapeutic care that was available to Milan was ECT and/or various oral medication in a form of anti-depressants. There was no other therapy offered to him.

80. The mental health treatment (ECT) was adequate and appropriate and also showed excellent results because he came out of depression after the 8th session. However, before ECT was over, Milan had in the meantime several very bad mental health episodes, including total loss of a sense of reality, trying to escape from the Edith Cavell ward leaving odd messages written on his bed, and physically attacking his natural father. Whether Milan's behaviour was connected to prescribed anti-psychotic medication, I do not know. But because his behaviour was so different to his normal behaviour at that time, I suspect that some of the anti-psychotic medication that he was taking either caused it or aggravated his already bad mental state.

81. Furthermore, in relation to Milan's medication, as I have touched upon above, I am not sure about the adequacy of oral medication he was prescribed and given as his behaviour was out of the real world at certain times. Whilst he was taking tablets, whilst being an inpatient, I did not really know what he was taking, and the doses. I only have minimal knowledge, having now considered a post-mortem toxicology report, that the following was detected from various samples taken:

    a. Quinine;
    b. risperidone (traces of antipsychotic medication)

82. Additionally, based upon the toxicology report, prepared by pathologist Dr T [I/S] and dated 20th September 2018, it is noted that he tested for Milan's *"…medication, diazepam and risperidone…".*

83. The pathologist commented that *"mirtazapine is used in the treatment of major depression"* and that *"the concentration in Mr Radovanovic's blood specimen is compatible with therapeutic use…"* He also commented that *"Risperidone is used in the treatment of psychoses, mania, agitation and aggression…"*

84. Relating to any concerns about how any of Milan's medication may have been prescribed and/or administered and managed, I do not have any comments. Furthermore, I have very little knowledge about the drugs he was prescribed. At times when he had episodes of irrational behaviour, I remember that after that, he was immediately visited by a doctor, and his medicine was modified accordingly.

Milan's individual conditions or circumstances

85. Milan was born in Serbia and lived there until the age of 6 when he and I moved to Maldon, Essex, during the civil war in Serbia, where I remarried, and we both settled in Maldon. Before I remarried, I asked Milan if he would agree with this, and he did, as he said our family would be complete.

86. Many years later Milan mentioned to his (privately arranged) psychotherapist that learning English at the beginning of his life in Maldon and adjusting to his new life without his grandparents who loved Milan very dearly was hard. He always showed a very brave face and never complained but carried on adjusting to his life in UK. He wanted to do his best, especially in his university years later. In his teenage years, things were not always going very well with Milan. Then he started experimenting with various drugs. Being caught with friends taking drugs during school hours and he was asked to leave his secondary Grammar School and had to move to another school.

87. Whilst Milan didn't have any special conditions, the circumstances including that he was originally from Serbia and that his mother tongue language was Serbian should have been considered by psychiatrists when dealing with his behaviours and symptoms.

88. Additionally, I do not think that the circumstances about Milan being separated at early age from his hometown and his grandparents were considered at all, when considering his mental state. Only Dr C questioned these circumstances, but she was just his private visitor and not his dedicated doctor.

89. I would have expected that the psychiatrist discussed Milan's childhood and opened up the issue of separation from grandparents and his biological father in Serbia and talk about it.

90. Unfortunately, I have never raised that issue myself and I regret.

91. As far as I can recall, I think that Dr D was aware that Milan's mother tongue was Serbian and it would have been beneficial for him to be communicated to in that language, as I informed him. Dr D, to my memory, was interested in the period of Milan's life when he was taking drugs and assessed Milan about is drugs taking, while I was present.

Safety

92. To the best my knowledge, prior to his passing, as an inpatient, Milan did try to escape from the Edith Cavell ward. It is my strong belief that if he had successfully managed to escape from the hospital, then he would probably have been in a position to harm himself, but luckily at the time he did not.

93. Whilst Milan was an inpatient under EPUT's care, I did not have any concerns regarding any aspect of his safety.

94. Milan was however, whilst an inpatient in Basildon hospital, was at several stages of his sections under the MHA, placed under 24-hour observation.

95. I am unaware as to whether there were inpatient stays during the relevant period at Basildon hospital where Milan was not placed under formal observations

My concerns regarding observations

96. When Milan was under formal observation, I found that some staff on duty were more helpful than others. There was a man, whom I cannot recall his name, who was much

kinder and showed understanding for Milan than others. He would take Milan in a wheelchair for a little wander in the main corridor and a café for a short while and they would then chat. Milan enjoyed these little tours out of the hospital bed. However, other members of staff, did not show much interest in doing anything else but sitting on a chair, not engaging and watching Milan, which I found very upsetting.

Leave, Absconsion and Awol patients

97. I do not ever recall Milan placing any requests for leave whilst an inpatient under section, at Basildon hospital, as he was too ill physically to be able to leave. Due to his perforated intestines, on request by Basildon surgeons not Milan himself, he was transferred to St Mark's Hospital, his original surgical hospital. He was treated at St Mark's, stayed there with no psychological and mental care whatsoever.

98. Milan left St Mark's Hospital on his own without letting anyone know on 17th May and turned up at home 18th May 2018. He said that there was no reason for him staying there as there was nothing going on that was helping him. Unfortunately, I don't know if Milan placed any requests for leave to the staff, whilst he was at St Mark's hospital, as he did not share with us his wish to leave the hospital at the time and just left on his own accord.

Milan's attempt to abscond

99. Milan once attempted to leave the Edith Cavell Ward and was found in another ward hiding in the small staff room. This happened during one of his psychotic episodes that I have already explained in my statement.

100. On 17th May 2018, Milan absconded from St Mark's Hospital, without letting anyone know. The police were informed on the same day of his disappearance.

101. Later on 17th May 2018, St Mark's staff urgently contacted us, explaining of Milan's disappearance.

102. On 18th May 2018, when Milan returned home, he explained to us that he had travelled home by train. However, he did not tell us where he had spent that night between leaving the hospital and arriving back home.

103. At the time of his arrival home, having absconded from St Mark's hospital, Milan still had his Peripherally inserted central catheter lines (PICC) inserted in his upper arm, which was how he was fed, on instruction of a nurse from St Mark's.

104. Later that day, police were notified that Milan had safely returned home. Again, later that day police officers visited him at home, to make sure that he was fine and had a conversation with Milan explaining that this was not a right thing to do as everyone was very concerned for his safety. He accepted these comments and apologised to police officers. He subsequently remained at home and did not return to the hospital until his death.

105. On 19th May 2018, Milan went on his own (he drove) to A&E at Broomfield Hospital so the PICC lines could be removed.

Transfer

106. Milan in both January and February 2018, was transferred between wards and units on multiple occasions.

January 2018

107. In January 2018, Milan was admitted to Broomfield Accident & Emergency. Upon admission, he was transferred to the general ward of Broomfield hospital, and he was subsequently transferred again to another general ward where he was assessed by **Dr B** During this admission, Milan was then transferred to Basildon Thorpe Ward where he was not admitted, but where he waited for few hours in the hall. Thereafter, Milan was transferred back to Basildon Hospital general ward (I cannot remember the name).

February 2018

108. In February 2018, Mlian was transferred to Edith Cavell Ward. Twice a week Milan would be wheeled to Thrope Ward from Basildon General ward for ECT sessions. After the final deterioration of his intestines, Milan was transferred to St Mark's Hospital, Harrow.

109. The reason for the transfer. I understood that there was no clear plan made for Milan's treatment while at Broomfield by Dr B, but the transfers from ward to ward were simply based on current availability of hospital beds.

110. Whilst Milan was an inpatient, I did not have any specific concerns about specific transfers because I thought at that time that decision makers concerning Milan's care and wellbeing were doing their best and that there would be improvement for Milan. However, I became very concerned when time was passing by, and it took a very long time to start helping Milan. We were desperate for Milan to start with his treatments (ECT etc) because he was both physically and mentally very unwell.

111. The only information I received from EPUT concerning Milan's transfers was just information given normally by a nurse on duty, or sometimes by a junior doctor, to inform me that he was going to be transferred to a particular ward.

Discharge and Continuity and Treatment in the Community

112. When Milan was initially admitted to Broomfield Hospital, Dr B expressed his firm opinion that Milan ought to be transferred somewhere else because at Broomfield, it would not be possible to provide care for him. I was never informed about the factual reasons and never received anything in writing. After a couple of weeks my understanding and feeling was that Dr B was determined to literally get rid of Milan as a patient by way of passing responsibility on to some other hospital who would be able to admit him and care for him.

Basis for discharging Milan

113. It was explained to me that there was no space available for Milan at Broomfield hospital psychiatric ward at the Linden Centre. After visiting Milan over several weeks on Broomfield wards, my opinion and gut feeling was that the psychiatric doctor avoided providing any psychiatric help to Milan, he showed clear neglect towards Milan. He also displayed dishonesty in how he communicated with Milan and with us as parents and showed a total lack of professional interest and human care for Milan and his psychiatric wellbeing.

114. As far as I can recall, Milan did not have much involvement in decisions surrounding his transfers during the first days of his stay at Broomfield Hospital. He was delirious due to dehydration and lack of food for days. Later on, Milan became more aware of decisions about his treatment. At the final meeting when a decision was made about the transfer to Thorpe Ward, he was engaged in the meeting. He then for instance wanted to know who all the clinicians were and what their roles were and was able to clearly follow what he was being told.

Discharge, formulation of a discharge plan, and/or arrangements for follow-up care in the community

115. While at Broomfield hospital, there was no discharge plan made for Milan to my knowledge. Also, while at Basildon hospital, I was not aware of any follow-up plan prepared either. The transfer from Basildon hospital to St Mark's hospital on 20th April 2018, was followed by a detailed medical report prepared by Basildon Hospital's [I/S] Dr E dated 20th April 2018. Regarding, Milan's mental health she noted that Milan was originally put under Section 3 Mental Act on admission but that the *'Psych team has lifted it now due to his remarkable mental health improvement. During his admission, he has been getting his ECT regularly and significant improvement on his mental state was noted in the last week.'*

116. I do not know whether there was a discharge plan prepared by RAID that was sent to St Mark's or EPUT (Essex Partnership University Trust) separately. In her conclusion of Dr E's report, she said that she attached in a white envelope documentation regarding the RAID team's involvement in Milan's care, which I do not have a copy unfortunately. However, it was noted by Dr E that the RAID team would appreciate an urgent referral to the local psychiatric liaison team covering their hospital for ongoing treatment, which was signed by Dr D, Locum MHU. As far as I know while Milan stayed at St Mark's hospital, there was no communication between EPUT and St Marks hospital.

117. After Milan's good recovery from depression, he became seriously ill with an intestine perforation again therefore, this was a priority then. We as a family believed that Milan's mental state stayed on a positive side however, while visiting him at St Mark's after the operation, his mood was becoming low again. I managed to have a conversation at my request then with St Marks psychiatrist Dr saw me on the corridor in front of. I expressed my concerns about Milan's deteriorating mental health, explained about

Milan's treatment at RAID, but did not feel I was really listened to. However, he assured me that he would visit Milan the following day to talk to him, which never happened. It was embarrassing to see that when **St Mark's psychiatrist saw me on the corridor in front of** Milan's room he literally turned round and disappeared.

118. Dr **[I/S]**, Milan's colorectal surgeon, showed a lot of care about Milan but did not refer Milan to psychiatric care. Why EPUT never got in touch with St Mark's to see Milan or talk to us his parents, I do not know. They showed an appalling lack of duty and care to Milan.

119. In addition to the above, there was no discharge and/or planning prepared in the community, to my knowledge for Milan. I haven't received any information either from EPUT during Milan's last stay at St Mark's. I was thinking at that time that Milan was not entitled to any care by EPUT but that he was completely under St Mark's. If I had known that Milan was still EPUT's patient, I would have had raised the alarm then.

120. In relation to advance notice of Milan's discharge date, I hadn't heard anything from St Mark's hospital or EPUT. I had been visiting Milan regularly and was not informed about any clear plan as to when he would be discharged. As I explained earlier in my statement, Milan left the hospital on his own initiative. He said to us that became fed up with the situation laying in hospital bed and checked medically without any mental care or support.

121. When Milan discharged himself on his own accord, I was given very little information that his care would be continued in the community under EPUT. I did not see any discharge plan or arrangements for him. There was no meeting held between us, parents, Milan and psychiatric team. **Mr A** from EPUT informed us on the phone that he would pay Milan a visit. He informed us that he would be paying a visit to Milan once a week and that someone will visit him to assess him so psychiatric medicine could be prescribed. I have no recollection of anyone else turning up in or home, at least Milan did not inform me about that. I have never received any information in writing from EPUT.

Concerns with discharge process

122. I was not happy with what was happening after Milan left and discharged himself from St Mark's hospital. He became very quiet, withdrawn and distanced

towards me and his stepfather and anyone else. He refused to see anyone including his close friends. There was nothing prepared or offered to Milan from the psychiatric team to help him feel better. I must say that on the day when Milan arrived unexpectedly home from St Mark's, the two policemen who turned up on St Mark's request to check if he was alright, showed more care and interest in how Milan was doing than EPUT worker, Mr A .

Concerns with EPUT treatment in community

123. Milan whilst under the care of the EPUT's community mental health team following discharge, did receive some community-based treatment / care. Milan from memory was receiving care in the community, once a week, for about an hour or less and he would be visited by Mr A (his specific qualifications were not known to me). At the beginning of Mr A's visits, he would ask Milan how he had been doing and then after Milan's reply he would ask Milan what his plan for the next week would be. That was it. I noticed that Mr A spoke in an authoritative style, like being in charge of Milan.

124. I recall that I would have short conversations with Mr A after his visits with Milan. I was desperate to get some facts and information of how Milan was doing mentally in Mr A's 's opinion. There were no results, Milan was becoming more and more depressed. To my understanding there was no real communication between Milan and Mr A. .

125. One day before Mr A's 's planned arrival Milan consumed a half bottle of an alcoholic drink which I did not know about and I only found the half empty bottle of spirit after Mr A's visit. Mr A complained about this event as he could not carry out his job. It was given in a written form which I received after Milan's death. Milan was not an alcoholic and since his illness from 2015, he would rarely have an alcoholic drink because it caused him abdominal pain. I still do not understand what and how that happened.

126. Further to the above, I was not aware that the EPUT community team, arranged and/or planned any mental health assessments for Milan. Between times at Basildon in April 2018, and his discharging himself from St Mark's in May 2018, Milan mentally

deteriorated and needed a careful assessment and attention. As I noted earlier the care included once a week a visit by Mr A who I understand was not adequately qualified or experienced or geared to provide adequate help and care for Milan at that stage. In my opinion Mr A did not establish a relationship with Milan and which would enable Milan to feel more positive. All the good that was built at Thorpe Ward was lost and never returned. If EPUT had done their job adequately Milan might have still be with us.

Engagement

127. Milan while being under RAID care, to my knowledge was involved in decisions regarding his care. However, while he was an inpatient at Broomfield and St Mark's hospital, that was not the case, and he was not involved in decisions relating to his care.

128. Staff, healthcare and other professionals at Basildon hospital and under RAOD communicated and engaged with me and my family reasonably well and we felt informed. However, whilst Milan was in Broomfield Hospital care, that was not the case.

129. My understanding was that doctors and specialists at Basildon hospital were listening to what I was saying about Milan's physical and mental health and that this was considered in order to help him better. In Broomfield hospital however, and whilst he was under the care of EPUT, there was really no one to talk to.

130. In addition, I was not able to input into those decisions, about Milan's physical and mental health by providing information about Milan's history and character. The main information I informed clinicians about at Basildon hospital was about schools Milan attended, university, social life and sports activities.

131. At Basildon hospital, I was informed in detail about ECT treatment. However, I was not presented with a psychiatric report from RAID addressed to St Mark's. EPUT provided me with absolutely nothing about Milan's treatment.

Contact with Milan while he was an inpatient

132. I was able to contact Milan via his mobile phone when I wanted to, and I was able to visit him frequently (I visited him nearly every day). However, attempting to

pass and/or seek information from staff and also to provide and/or receive information about Milan, was fraught with difficulties.

Engagement concerns

133. I am of the strong opinion that the support for Milan pre and post Basildon stay at hospital, was totally inadequate.

Concerns and Complaints: Quality, Timeliness, Openness and Adequacy of Responses

134. I also had concerns about Milan's observations and checks, as I felt 24-hour watch was not always adequate. He had 24-hour watch near his bed, observed him continuously. Some carers were kind and helpful, engaging with him. Chatting with Milan, taking him out in a wheelchair. Somewhere not, being cold and detached.

135. Additionally, I felt that the ward environment was inappropriate at Edith Cavell Ward for Milan's needs, as there were too many patients in a small. Furthermore, there was a lack of fresh air, no space to walk around and overall, it was a visually unpleasant space for someone who was in poor mental health.

136. I did raise concerns regarding inadequate EPUT care for Milan from May until 28th April 2018 when he left St Mark's Hospital and became a patient of EPUT. I placed an informal complaint through conversation with Mr A after one of his visits, i.e. I expressed my concern about Milan lacking more care and lacking in him talking to a trained psychologist. However, I received no response / no action was taken.

Milan's death

23rd July 2018

137. On Monday 23rd July 2018, I had spoken to Milan's mental health care nurse, Mr A, who told me that he had spoken to Milan, who had said that he was going to visit his friend, [I/S], in Little Hampton near Brighton. However, I have received a text message from the friend, who advised that he did not actually see Milan.

24th July 2018

138. On Tuesday 24th July 2018, Milan returned home at 20:00 hours and he was quiet and serious. He was very distant and spoke to family members who were at our address. Milan was also very dehydrated, tired and affectionate towards me.

139. About 21:30 hours he went up to bed but came back downstairs and made himself a toasted sandwich.

140. At 23:00 hours I was in my bed reading a book with Kevin next to me, when I saw Milan walk from the bathroom towards his bedroom and as usual, Milan quietly said *"night"* and went upstairs to his room, in the attic area. I then went to sleep until I woke the next morning about 7:30am.

25th July 2018

141. On 25th July 2018, after going for a walk with my husband, we returned home and I began to prepare a midday meal and I said to Kevin, *"isn't Milan getting up?"*. With this Kevin went upstairs to wake Milan up. I then heard Kevin raising his voice and then Kevin then ran back downstairs and said, *"I'm not getting any answer and I can't open the door."* I said *"oh no!"* and we both went upstairs and I saw that Milan's door was closed and barricaded.

142. I then saw Kevin climb out onto the roof parapet and went to Milan's room dormer window and attempted to open this window. However, it was bolted shut and Kevin returned. I remember waiting for Kevin to come down to the workshop and get some tools. When Kevin returned he was carrying a crowbar and I saw him attempting to crush the door latch which seemed to have been fixed in place, locking the door. Although when this latch was bent out of place, the door could still not be opened, as it appeared to have been barricaded from the inside.

143. I then saw Kevin push the top of the bedroom door and look inside and look inside Milan's room and then say "he hung himself".

144. Milan was found by my husband, Kevin Fuller, in his bedroom and suspended with a rope tied around his neck and hanging **[I/S]** in his bedroom. At the time

that Milan was found, I was immediately behind my husband when he found that Milan's bedroom door was barricaded shut.

145. I then looked for myself and saw my son Milan hanging [I/S] facing away from the door [I/S]. Kevin and I then returned downstairs and Kevin called 999 and called for assistance.

After Milan's death

146. In relation to the processes that would take place i.e. internal investigations or an inquest, we were not told anything.

147. In addition, after Milan died, I cannot remember if we were offered any support at that time. In all honesty, I don't think we were. Even if we were offered support however, I think we would decline it, because we were so upset and there was nothing could be done to bring Milan back.

My concerns / comments regarding the process after Milan's death

148. After Milan died, EPUT had sent me an email for some reason which I cannot remember now what it was. They addressed in this email about my son Milan as 'your daughter Milan'. This had really upset me, and I did complain about it. They eventually apologised and wrote that the email was written by a young inexperienced member of staff and who felt embarrassed and upset because of the mistake she had made.

149. On a positive side, two ladies visited my husband and I at home very shortly after Milan's death to pass on their sympathy and condolences. They showed genuine compassion and sympathy while talking to us which we appreciated. I do not know whether these ladies were from EPUT or another organisation.

150. On another occasion, I was invited for a meeting with a group of EPUT or NHS staff (all administrative staff). They invited me and organised this meeting for one hour before the Inquest was to be held. There were I remember 3 ladies in the meeting with me. During the meeting, I was presented by these staff some Excel charts, where they stated what lessons were to be learned from Milan's death and some other facts. I could not believe that they were showing me these charts and their dry wording which represented the absolutely most tragic event when one young life was lost forever and that was my own son. I felt so very sad and angry. It was a terrible experience.

151. The Inquest, however, was carried out with dignity and respect both towards Milan's death and towards me (my husband could not attend). The judge was very respectful, and her speech was very well balanced including all aspects of Milan's death. Although she did not go into depth of the poor psychological care for Milan in the past which EPUT was responsible for.

152. Following an investigation that commenced on 3rd August 2019 and an inquest hearing at Essex Coroners Court on 29th November 2018, the Coroner recorded a conclusion of suicide by hanging.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

153. After Milan died, I do not recall that to my knowledge that there were any investigations undertaken by and/or arranged by the Trust or any other relevant mental health provider. Perhaps this may have been the report in Excel form that was presented to me prior to Inquest which I described above. If that is the case, it was completely inadequate and inappropriate. I glanced through it and left it with them EPUT.

154. However, having considered the documents in my possession, I note that there was a root cause analysis investigation report prepared by EPUT, dated October 2018, which I have considered, and which constitutes an investigation into the death of Milan.

155. *In their report, EPUT as an overview surmised that Milan "…had been admitted to Broomfield Surgical ward and was referred to the Access & Assessment Service on the 10/01/18. He was reviewed by a psychiatrist and on the 6th February 2018 he was detained under Section 2 of the Mental Health Act. MR was then transferred to Thorpe ward at Basildon Mental Health Unit. MR was diagnosed with Mixed Anxiety and Depressive Disorder.*

156. *On admission to Thorpe Ward there were concerns about his physical health and on the 7/02/18 he was transferred to Basildon General hospital. Following his transfer to the General Hospital he was referred to the RAID Team. MR was then transferred from Basildon General Hospital to Northwick Park Hospital for Surgery to his bowel. Following this he self-discharged on the 16/05/18 from Northwick Park Hospital and was followed up by* Mr A *Advanced Nurse Practitioner and care co-*

ordinator from the Specialist Mental Health Team. MR received weekly visits from Mr A *commencing on 29/5/18.*

157. *On 10/07/2018 MR was visited at home by his care coordinator* Mr A *MR was reported to have responded to his medication positively and his mood had improved slightly, however he continued to present as low in mood and flat in affect.*

158. *On 20/07/18 MR had an appointment with a psychiatrist at Cherry Trees Hospital which was cancelled. However MR's care coordinator visited him at home and reportedly found the patient heavily intoxicated with alcohol.*

159. *On 23/07/2018 the care coordinator made phone contact with the patient who was on his way to Brighton with a friend and appeared "upbeat". The care coordinator reminded him of two home visits that had been scheduled for 26/07/2018.*

160. *On 24/07/2018 the care coordinator attempted to contact MR on the phone however there was no answer so a message was left.*

161. *On 25/07/2018 the care coordinator attempted to contact MR and was informed by the patient's step father that he had been found deceased in his bedroom that morning.*

162. The trust made several recommendations, following their investigation, which include the following:

163. *"…The investigation team found accessing information difficult across all areas of the Trust.*
Therefore:

164. *1) Clinicians to be made aware that they can access the Health information Exchange to easily assist with information sharing within the trust.*

165. *The investigation team found risk assessment and care plans were not updated and were found not be robust or detailed Therefore:*

166. *2). The Clinical Manager to ensure that all staff are up to date with Clinical Risk mandatory training.*

167. *3). The Clinical Manager to ensure that risk assessments are regularly reviewed and updated through the supervision structure.*

168. *4). The Clinical Manager to review and audit Care plans to ensure they are patient centered and reflect individual needs.*

169. *5). The Clinical Manager to review and audit risk assessments to ensure that they are robust and appropriate and that this is reflected in the risk management plan.*

170. *The investigation team recognizes that although there was communication between the care coordinator and the family, it is not documented that issues of confidentiality and respecting MR's wishes were explored. Therefore:*

171. *6). SMHT to be aware of the importance of discussing confidentiality and consent, and ensuring that this is documented.*

172. *7). SMHT to ensure carers assessments are offered and that part of this process includes a discussion focusing on confidentiality, consent and information sharing.*

173. In terms of the findings the RCA report found that in relation to the communication between physical and mental health services, that whilst "*…MR received treatment from both physical and mental health services…there is limited recorded evidence of liaison between both services."* Additionally, *"…it appears that the SMHT were not aware of the transfer of MR's care to Northwick Park Hospital, until the care coordinator visited Edith Cavell Ward in Basildon General hospital on the 27/4/18"* and *"…were not aware that MR had self-discharged home from Northwick Park Hospital until they visited Northwick Park Hospital on the 23/5/18."*

174. The RCA report also found that *"…From interviewing staff it was felt that there was insufficient information available from the general hospital regarding MR's physical health, and that there were issues with sharing information with mental health. There was inadequate communication between Thorpe ward and the SMHT following his admission to Basildon General Hospital.*

175. *Overall the main communication issues were between physical and mental health services. Due to communication issues the care coordinator was not aware of*

where MR was being treated.

176. *Overall, no care plan recognized the adjustment it would require for MR to manage the physical changes to his body due to the stoma and the effects this had on his mental health.*

177. EPUT in their RCA, also recognised when referring to the adherence to their Care Programme Approach (CPA) Policy that the Trust's CPA policy required a clear, shared, and understandable care plan which outlined responsibilities, timelines, and rationale for care.

178. It was acknowledged that there were three care plans created for Milan, which were created on 29/05/2018:

- One scheduled psychology appointment (31/05/2018).
- One stated a care coordinator needed allocation, though this had already occurred on 01/03/2018.
- One stated Milan was to be reviewed by a psychiatrist.

179. Additionally, EPUT with regards to the CPA policy in the RCA noted that there was an appointment for Milan to see a medic which was arranged for 20/07/2018, but which did not occur, and furthermore, where there was no documentation confirming the cancellation or a follow-up appointment on 23/08/2018. There was also acknowledgement that no correspondence was sent to Milan about these appointments.

180. The RCA report also highlighted that Milan's initial assessment and risk assessment were completed on 20/04/2018 and signed off on 25/07/2018 but not updated despite regular contact with the care coordinator **Mr A** and new concerns raised by Milan on 10/07/2018 (expressing hopelessness).

181. The risk management plan (20/04/2018) included regular care coordinator input, psychiatrist and psychology involvement, contact details for support, and escalation options (HTT/stepped-up care). However, all three care plans (authorized 25/07/2018) recorded *"no change"* to risks, and there was no evidence of risk reassessment after April 2018.

182. The investigation also found some SMHT staff were not up to date with mandatory clinical risk training.

183. Other issues highlighted by EPUT in relation to the care provided to Milan, were in respect of the electronic databases. It was noted that *"…EPUT currently have two clinical database systems, one in the North (Remedy), and one in the south (Mobius) and the sharing of information is difficult to access. This created difficulties for the care coordinator* **Mr A as it was not** *possible to access information from RAID to see the up to date clinical notes. It is recorded that* **Mr A** *attempted to make contact with the RAID team to access information verbally instead, but messages were not responded to."*

184. With respect to root causes, EPUT found that the *"…Investigators were unable to identify specific and distinct root causes, but have detailed associated factors which may have had an impact."* Furthermore, with respect to lessons to be learned:

1. Risk assessments were completed on the 20/4/18 but were not updated.
2. The care plans were not patient centred relating to MR's physical health and mental state.
3. Communication between SMHT and the family appeared limited and there is no documented discussion with the mother explaining their role and limits to confidentiality.

   The Initial assessment conducted on 20/4/18 showed that a carer's assessment was offered but this was not actioned.
4. The trust has two electronic database systems and the investigators noted there were difficulties in requesting and accessing records.

Other investigations

185. Essex police prepared a police incident report dated 21 August 2018, for the coroner. The incident report had a statement from me providing an insight into Milan's life and circumstances leading up to his passing.

My views / reflections

Positive views

186. There were some positive aspects about Milan's mental health treatment, for example the ECT carried out by RAID team was successful and after 8 treatments Milan showed very good improvement.

Milan's views

187. Milan whilst as an inpatient, did raise concerns and complained about headaches during his ECT treatments and nearly refused to carry on but in the end he persevered.

My major concerns / serious failings

188. I consider that the most serious failing by EPUT, was that very late intervention was the main reason for Milan's spiralling deterioration in his mental health. His prescribed medication often was not working as he went several episodes of being out of the real world. There was also no transparency from EPUT in sharing information with the family.

189. I personally think that Milan desperately needed to talk to someone at time of his first operation, who would be able to fully understand his problems since the very beginning of his mental health deterioration at this time, along with involvement of the family. I think we fairness we all failed to understand Milan's problems, including doctors/clinicians, family and friends.

My views on the Inquiry's Terms of Reference / List of Issues

190. I believe that the Inquiry should investigate the significant deficiency of qualified psychotherapists, psychologists and psychiatrists, which I feel represents the main problem that is causing poor mental health care in Essex. Until this problem has been resolved, mentally ill people like Milan will be suffering hugely. It is clear to me that in Milan's case the inadequacy of staff (EPUT's **Mr A**), lack of caring for their

patients, and lack of honesty and ethical approach (including Broomfield, St Mark and local GP surgery) towards Milan proved to contribute to deterioration of my son's mental health which in the end lead to his suicide.

Recommendations for Change

191. The changes that I would like to see reflected in the Chair's recommendations, I have mentioned above. But I will repeat that there should be more resources put into qualified psychotherapists, psychologists and psychiatrists, to ensure that inpatients and/or those in the community receive appropriate and high-quality mental health care.

Statement of Truth

I believe that the facts stated in this Rule 9 Witness Statement are true.

Signed: [I/S]

Full Name: ANASTASIJA FULLER

Dated: 25 November 2025

List of Documents

I attach the following list of documents

1. Root Cause Analysis Investigation Report
2. Anastasija Fuller's Witness Statement for the Police
3. Anastasija Fuller's Witness Statement for the Inquest
4. Record of Inquest
5. Post Mortem Report
6. Toxicology Report
7. Serious Incident Action Plan
8. Discharge Summary - 20.01.2016
9. Discharge Summary - 01.03.2016
10. Blackwater Medical Centre Patient Summary
11. Patients Questions - May 2018
12. Email by parent addressed to [I/S], consultant, seeking help for Milan at St Marks - 14.08.2015
13. Email correspondence between parent and St Mark's requesting help regarding Milan's mental health - 01.11.2017
14. Email chain with [I/S] EPUT - May 2018
15. Email Chain with St Marks Hospital London - 21.02.2018
16. Email chain between Essex Police and the Coroner's Officer - July 2018
17. Email correspondence between parent and St Mark's hospital requesting help about Milan's deteriorating mental health 21.02.2018
18. Letter re Nutrition and Dietetic with EPUT
19. Letter to Confirm that Milan was in critical state with the invitation for his father in Serbia to visit - 14.02.2016
20. Letter from Pouch Nurse Specialist [I/S] - London North West Healthcare NHS Trust - 01.03.2016
21. Letter to Blackwater Medical Centre from [I/S] London North West Healthcare NHS Trust - 13.04.2016
22. Three letters signed by [I/S], St Mark's outpatient review, considering reconstructive surgery - 01.11.2017
23. Letter from London North West Healthcare NHS Trust - [I/S]s Surgical Clinic - 02.11.2017
24. Letter to Northwick Park A&E from Dr E - April 2018
25. Letter from London North West Healthcare NHS Trust Surgical Clinic - 31.05.2018

26. Broomfield Hospital Discharge letter after the total colectomy by [I/S] - 10.04.2015
27. St Mark's preassessment letters regarding reconstructive surgery - 23.10.2015
28. Broomfield Hospital letter regarding options for reconstructive surgery - 17.06.2015
29. Broomfield Hospital discharge letter after first complications post-op - 06.05.2015
30. GP's home visit report and request for Hospitalisation - 01.02.2016
31. Isle of Wight discharge letter ,surgery after prolapse - 14.09.2016
32. [I/S]'s (Blackwater GP Surgery, Maldon) Handwritten note - 20.03.2015
33. Referral for investigation by GP Surgery - Blackwater Medical Centre, [I/S] - 17.03.2015 (audio files)
34. St Mark's Hospital review letter signed by [I/S] - 30.05.2018
35. Report addressed to [I/S] (St Mark's Nortwick) before discharge, signed by Dr E Basildon Hospital - 20.04.2018
36. Observation Report, Basildon Hospital - 08.02.2018
37. Collection of Observation Reports, Basildon Hospital – 02.04 to 20.04.2018
38. Essex Police Incident Report - 25.07.2018
39. EPUT Letter of condolences and their chronology of events - 16.08.2024
40. Brief History of Milan's illness
41. Milan's Story
42. Short statement of Anastasija
43. Milan's draft for personal care and recovery plan - EPUT template, undated
44. Inquest recording