WITNESS STATEMENT OF JUNE DICKS PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **Mrs June Dicks** **[I/S]** **[I/S]** am the mother of Terry Dicks (born on 17th August 1971; died on 16th April 2018.)

2. I am making this statement from a combination of 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 26th September 2018.

Diagnosis

3. Terry started showing signs of what we can only describe, as an emotional breakdown in and/or around 2009, when his relationship with his ex-wife broke down. Terry got divorced in 2009, following which he lost everything, including his job in finance, which he had done for the majority of his life and his property.

4. After Terry's divorce, he came to live with Roy (my husband) and I. At this point in his life, it was clear to us in his behaviour and outlook that, he was deeply distressed by what had transpired in his life. During this time, we encouraged Terry to rethink about his future and to look for new employment and suggested that he go back to college for better employment opportunities.

5. Terry was keen to get a place of his own, and so he registered with Genisis Housing Association.

6. In 2012, Terry moved into a place of his own. But for as long as we could remember, Terry would always come home with his son, every Sunday, for lunch to watch football with Roy. We always tried our best to support Terry in whichever way possible.

7. We first noticed Terry first becoming really unwell mentally, in Spring of 2015. This coincided, with Terry losing his job, as a Taxi driver. This led to Terry, as noted in the

Root Cause Analysis investigation report (RCA) dated August 2018, at page 10, of feeling *"…deeply depressed at this time and that he had lost all confidence in himself, particularly relating to his employment, due to mental health stigma".* We as a family echo this, that there was a sharp decline in Terry's mental health which had been building up over a period of time, to the point where we felt he had become depressed.

8. To illustrate how depressed Terry was in 2015, I recall once when I was at work and Roy (my husband) was coming home. When Roy approached the house, he saw and noticed that all of our windows were opened. Roy was very worried that we had been robbed but it was in fact Terry who had opened them all for no particular reason. We concluded that Terry was not himself and had mental issues that required support.

9. During this period, Terry was suffering from what we would categorise as hallucinations and delusions. It was extremely frightening for us. Terry during this time, would speak about the television and the world. He would be talking to himself, and we couldn't understand him. I repeat it was terrifying. It was at this point as a family, that we concluded that Terry needed medical help. We were so frightened for him, as we had never seen anything like this from him before.

<u>First contact with mental health services</u>

10. In April 2015, Terry first came into contact with EPUT's Mental Health Services. Roy called NHS 111, as Terry was aggressive towards us and we knew he required urgent help that we could not provide him.

11. Following Roy's call to NHS 111, an ambulance arrived, and the police also came to assist us with Terry's worrying behaviour. Terry was then admitted to Rochford Hospital (Cedar ward) under section 3 of the Mental Health Act (MHA) to be treated for a drug induced psychosis. Whilst under section at Rochford Hospital on Cedar Ward, for his mental health, Terry was diagnosed with schizoaffective disorder (F25.0). The family were not made aware of this diagnosis.

12. Unfortunately, having reviewed Terry's medical records and other associated documents, we have not come across and/or have not been able to determine, the exact date this diagnosis was given, who diagnosed Terry and on what basis Terry was diagnosed with schizoaffective disorder.

13. We strongly request that the inquiry legal team, obtain EPUT records, to enable us to get an understanding / idea as to the basis for Terry's diagnosis of schizoaffective disorder.

14. We do recall however, that upon Terry's first section under the mental health act, at Basildon Mental Health Unit, he was an inpatient for 28 days before being discharged back to his home. This was the start of a 3-year period of lapses in his mental health which led him to be sectioned 3 times and ended with his untimely death on 16th April 2018.

Assessments

20 February 2018 – Terry attended EPUT outpatient appointment

15. On 20 February 2018, Terry attended an outpatient appointment with care co-ordinator **(CC)** undertaking the appointment. It is noted at page 54 of the combined records, that during the appointment, Terry spoke about *"…feeling upset the church had authorized telecommunications companies to put 5g pylons on their land…"* and being *"…concerned this will lead to disease and illness such as cancer and blocks the signal and connection…to God."* Terry also spoke about there being a *"…conspiracy by the governments and none of us realising the risks. He was laughing at times when talking about this and how there are demons walking amongst us and said he saw them before his last admission…"* It was noted that during the appointment that *"…Terry continues to have delusional and paranoid beliefs…"* and that there would be a discussion *"…in MDT tomorrow"*.

16. Whilst Terry and/or any family did not request and/or seek a mental health assessment in relation to admission, following this appointment. It is my strong view, based upon the notes of the comments that Terry was making during the appointment, that a Mental Health Act assessment was warranted. I, therefore, want the inquiry team to investigate two things in relation to this outpatient appointment.

17. Firstly, I would like the inquiry to investigate why EPUT were of the view that a MHA was not mandated?

18. Secondly, that the inquiry obtains from EPUT, the notes from the Multidisciplinary Department Team (MDT) meeting, that was to take place on 21 February 2018, as this

will assist me in understanding the reasoning that a MHA assessment and/or any further stronger intervention for Terry was not considered at this time.

20 March 2018 – Terry attended EPUT outpatient appointment

19. On 20 March 2018, Terry attended his outpatient appointment with Consultant Psychiatrist, Consultant Psychiatrist 1 It is noted at page 57 of the combined records, that during the appointment, Terry explained that he allegedly had *"…no thoughts of harming himself or others and stated he was Christian so wouldn't do that".* But then it is noted that Terry displayed *"…some paranoia…about society and organisations…and…hostility and irritability…"* Terry was then *"…discharged from care coordination."*

20. Consultant Psychiatrist 1 in his outpatient clinical report to Terry's GP dated 23 March 2018 at page 59 of the combined records, noted the following:

".. CC *expressed the view that Terence is possibly not taking his medication* [Olanzapine 10mg nocte]…*His mood subjectively and objectively was euthymic and his affect was reactive. He did not express any suicidal or homicidal thoughts or plans. There were no psychotic symptoms or perceptual abnormalities elicited…"* This information contradicts what CC said to Terry on 20 February 2018.

21. Again, in relation to this outpatient appointment, even though Terry and/or any family did not request and/or seek a mental health assessment in relation to admission, following this appointment. It is again my strong view, despite Consultant Psychiatrist 1 assessment, that based upon the notes of Terry's presentation and the comments he was making during the appointment, that a Mental Health Act assessment was warranted.

22. I would again request that the inquiry team investigate why EPUT were of the view that an MHA was not mandated on this occasion and why they were happy to listen to Terry regarding discharge from care co-ordination, whilst he was suffering from mental health issues?

11 April 2018 - Decision made that a Mental Health Act assessment required

23. The following details relating to the decision on 11 April 2018, that Terry required a MHA assessment, largely emanates from the root cause analysis (RCA) report, which

forms part of my list of documents. Whilst I have drawn from the RCA, there are aspects of the same, that I do not agree with and which, have been addressed within the *"Addendum to RCA report"*.

24. On 09 April 2018, Terry's sister [I/S] contacted the Recovery and Wellbeing Team (RWB) expressing concerns that that she felt Terry was relapsing, as he was presenting as *"manic"*. She had accompanied Terry to town over that weekend, and she recalls that Terry was overly friendly with people, but also paranoid. She could not go into a café with Terry because he thought a man in the café was watching him. She also remembers that Terry looked unkempt and unshaven, which she knew to be out of character for him.

25. His sister was also concerned that Terry had not been taking his medication and had little insight into his illness. She recalls, that Terry was still not talking to Roy and I, as he blamed us for having him sectioned to hospital. Therefore, she mentioned to RWB that as she was the only family member that Terry trusted, that the RWB team do not make Terry aware of her contact, as she feared that Terry would lose contact with her also. She was informed that the care coordinator was on leave that day, but that she would be informed about her concerns the following day.

26. On 10 April 2018, the care coordinator, CC, discussed Terry's case, at a Multidisciplinary Team (MDT) meeting. During the meeting, it was agreed that due to the indication of Terry relapsing and his high risk of paranoia, that CC would do a joint visit to Terry's home with the RWB Team Lead, (RBW TL)

27. CC later spoke with his sister and she explained that she had observed that Terry had lost weight from when she had seen him two weeks ago. She also described to CC [I/S] that Terry had been talking to strangers and that he was displaying paranoia when in public places. She went on to explain that there seemed to be a pattern to Terry's illness and noted that his present behaviour was reminiscent of how he behaved weeks leading up to being sectioned over the last few years. She also explained that Terry was putting bizarre messages on his Facebook page and reiterated that she felt that he was not compliant with his medication.

28. His sister went on to inform CC that Terry's GP surgery had confirmed that he had been collecting his prescriptions regularly. She also said that Terry was able to come across as calm and rational, but that she knew him well and could detect the relapse signs. His sister stated that she had received a text from Terry at 7am that morning and

he stated that he was going to stay with his partner for a few days, who had just moved to Crawley. His sister agreed with CC that she would inform her when Terry returned home and would also contact RWB if she had any further concerns.

29. On 11 April 2018, CC is said to have received an email from Terry's sister informing her that Terry had turned up at her house and was speaking to her husband. She indicated that her husband was quite concerned with Terry's presentation, as during conversation he was making references to the devil and the end of the world, which both his sister and her husband found quite alarming. His sister was told by CC that she would do a cold call to Terry's flat that same afternoon, along with her colleague [I/S] as the team lead was not available at that time.

30. At 1.30pm on the same day, CC arrived at Terry's flat. Initially there was no response from the flat when they buzzed, but Terry came from the side entrance to see who it was. CC described Terry's presentation as hostile and angry. He was apparently swearing stating that he *"…can't believe this is happening again"* and *"unbelievable"*. Terry was also said to not have allowed the RWB team to explain the purpose of their visit but became verbally aggressive and uttered statement of a psychotic nature. Terry also stated that he did not wish to speak with them further, so they left the property.

31. Due to Terry's presentation upon RWB's visit and the level of deterioration in his mental state, CC and Colleague agreed that a request for a mental health act assessment (MHA) would be the appropriate course of action. Upon returning to the office CC discussed Terry's case with the duty AHMP, AMHP 1 and subsequently emailed the completed AMHP referral form over to the AHMP service. CC informed Terry's sister of AMHP's 1 referral for Terry and advised her that it may not take place until the following day, as they had to secure a warrant to gain access to the property.

32. CC also informed Terry's sister that AMHP 1 will notify the family of the outcome of the referral and that she could contact Duty, if she did not hear from them by Thursday (12 April 2018). Further, CC informed her that she could contact the police if she had any further concerns about Terry's wellbeing, so as to elicit a welfare check. CC also informed Terry's sister that she was going to be off duty for the next few days, but that she would hand over the case to the team lead RWB TL who would deal with it in her absence.

33. On 12 April, Terry's sister made various phone calls to RWB's RWB TL throughout the day, to chase up what was happening in respect of Terry's MHA and care, but nobody was keeping us informed and did not seem to know what was going on. Responses

were inadequate. RWB TL didn't seem to know what was going on and he was at times very rude about Terry's sister continuing to call. RWB TL also never responded in a timely manner and didn't realise the seriousness of the case.

34. On the morning of Friday 13 April 2018, Terry's sister again contacted RWB TL of RWB to get an update on the AMHP assessment, as she was informed that the warrant would be obtained on 12 April 2018. She stated that RWB TL of RWB informed her that they had obtained Terry's warrant, but he would enquire from the AMHP service and call her back. However, she later that day received a telephone call from RWB TL, in the afternoon and he informed her that he had made a mistake as the warrant was not achieved and that four warrants were received, but that Terry's was not one of them.

35. Terry's sister stated during the call that RWB TL blamed a student who was working with them and stated that Terry's warrant would not be obtained until 16 April, with 35. Terry's sister of the strong opinion that RWB TL lacked compassion in his responses to her enquiries regarding the execution of the warrant.

36. On 14 April, Terry's sister stated that she became more worried about Terry's mental state and contacted the emergency duty team who advised her to either get Terry to accident and emergency (A&E) or contact the police to do a welfare check. In response she explained to them that the family were unable to get Terry to A&E, as they had tried this route before and there was no way that Terry would accept it again.

37. She also informed the emergency duty team that the police welfare check would not achieve anything as Terry would tell the police that he was ok. There was no support available for him and/or the family over the weekend, at the time when he desperately needed help.

38. Terry's sister was very concerned about Terry's mental state, due to the nature of the texts she had received him from Terry. She also attempted to visit Terry on Saturday 14 April 2018. She said that in desperation she emailed CC on Sunday evening, asking her to make contact urgently. The AMHP service confirmed receipt of the referral from CC on 11 April, also that an application for a section 135 warrant was emailed to the court on Thursday 12 April, with a booking for the application to be heard on Friday 13 April 2018.

39. AMHP 2 reported that an error occurred with the electronic booking, in that, he had mistakenly booked a date that had already passed. This was apparently picked

up later by the court administrator and advised AMHP 2 that he needed to make another booking, but unfortunately the next available booking date for the case to be heard by the magistrate was Monday 16 April.

40. On Monday 16 April the warrant for Terry was obtained at 15:45 and AMHP 2 then contacted the police. At 16.07, the police allegedly confirmed that they would be able to facilitate the warrant and also a MHA assessment on Wednesday 18 April at 10.30, which was booked, which was however, too late, as Terry had taken his own life on 16 April, after he had thrown himself out of the [I/S] window of a Tower Block.

41. On the morning of 17 April, Terry's sister received a telephone call from RWB's RWB TL where rather than sending his condolences, he opened the conversation by stating *"have you heard what happened to T"*. RWB TL then continued the conversation by saying CC *"was in bits",* that they now had Terry's warrant and that the MHA was organised to take place on Wednesday 18 April at 10.30. Terry's sister rightly felt that it was wholly inappropriate for RWB TL to share this information with the family, just hours after Terry had sadly and tragically passed away, as by this time it was clearly too late. Terry's sister also felt that RWB TL overall comments were insensitive and lacked empathy and also was of the opinion that his attitude was unprofessional.

42. The reason we feel that delays in obtaining the warrant were avoidable, is that there were clear mistakes made by EPUT on 12 April 2018. This included a lack of communication in somebody else taking over from Care Coordinator from Wednesday 11 April to Thursday 12 April 2018. This in our mind contributed heavily to Terry not receiving the timely care that he so desperately needed and should have received. Had he received the care he should have, Terry would likely still be with us today.

04 April 2015 – Terry's first section under MHA.

43. As I have detailed above, Terry was initially sectioned on 04 April 2015, under section 3 of the MHA, due to an emergency/crisis assessment that stemmed from him being aggressive towards us, and us as a family feeling he required urgent help for his mental health issues.

44. Terry following an assessment at Rochford Hospital was sectioned for a period of 28 days at Basildon Mental Health Unit. However, I do not know anything about this assessment, for example when an assessment was carried out that led to his

sectioning and/or who carried out this assessment. I can also confirm that neither myself and/or any family members were present during the assessment that led to Terry's sectioning at this time.

45. The only details I know about Terry being sectioned in April 2015, according to the Root Cause Analysis Investigation Report dated August 2018, is that Terry *"…presented with florid psychotic symptoms and…paranoid and agitated…".*

46. I would, therefore, be grateful, if the inquire team would obtain Terry's assessment record from EPUT, so we can have a better understanding, as to when exactly the assessment took place, who undertook it and details of the assessment.

01 December 2016 – Terry sectioned for the second time

47. On 01 December 2016, Terry was sectioned under section 2 of the MHA, at Hadleigh Unit Psychiatric Intensive Care Unit (PICU) following an urgent mental health act assessment at Basildon hospital. The reason for this assessment was that Terry according to the Root Cause Analysis Report *"…presented with florid psychotic symptoms and paranoid delusions…".* At this time, we as a family were doubtful also that Terry was compliant with his medication (Olanzapine).

48. Additionally, as mentioned on page 120 of the combined records, Terry's *"…current admission came about as a result of concerns…that Mr Dicks was experiencing mental health difficulties, which were initially expressed to the first response team last month. He had been seen talking to the television, and on 01 December…he was found by family members at Southend Station staring at the sun and talking to it…"*, so we *"…took him to his GP, who owing to his presentation recommended he be taken to A&E for assessment…"*

49. In the lead up to this section, Roy and Terry's sister had managed to get Terry to A&E where we waited a very long time for doctors to assess him. I recall it being an extremely stressful and difficult situation as Terry didn't want to be in hospital and wanted to leave. Security guards at the door made sure that it was secure and Terry couldn't get out. Once Terry had been assessed, Roy and Terry's sister were asked to leave him, so that Terry could be taken to a secure unit at Rochford Mental Health Unit.

50. On 05 December 2016, the First-tier Tribunal Mental Health decided not to discharge Terry from liability to be detained and thereafter, on 07 December 2016, Terry was transferred to Rochford Hospital, prior to being to being transferred to Cedar ward on 19 December 2016, after agreeing to informal treatment.

51. Again, I do not know anything about the assessment that led to his sectioning on this occasion, when and who carried this assessment, other than that noted on page 121 of the combined records, which state that *"…reports of the assessment describe Mr Dicks as expressing a number of delusions including beliefs involving conspiracies, having instructions from God and the Queen to rid the world of child abuse, being able to control the sun's heat and having information regarding a nuclear attack.."*. I again confirm that neither myself and/or any family members were present during the assessment that led to Terry's sectioning on 01 December 2016.

52. I would, again be grateful, if the inquiry team would obtain Terry's assessment record from EPUT for his assessment that led to his 01 December 2016 sectioning, for the same reasons I have outlined above.

October 2017 – Terry sectioned for the third time

53. Terry had been unwell for a while and, as a family, we were worried about his safety and wellbeing. We called the mental health team who came to Terry's flat. Due to how Terry was presenting, we did not want to be there on this occasion when they sectioned him, as he had blamed us previously for a his previous section. Therefore, we thought it was best that, this time, we left it to the medical team. Although we were not actually with Terry at his flat, we waited outside to ensure that the mental health team went through with the decision to section him.

54. As a result, on 25 October 2017, Terry was admitted to Southend hospital, Cedar Ward under section 2 of the MHA, with evidence of a paranoid psychosis secondary to poor concordance with medication and use of cannabis. This was after being referred to EPUT Approved Mental Health Professional (AMHP) Consultant Psychiatrist **[I/S]** Consultant Psychiatrist 2 for an emergency assessment, after refusing an informal admission.

55. According to page 489 and 490 of the combined records what lead to the assessment was that "...Terry's sister *reports the family have been concerned about Terence for the last four weeks ensuring that he visits them regularly and have encouraged him to stay*

with June and Roy. However, on 22nd Oct. while staying with his parents and other family members were visiting including his niece and her baby he ordered the family to stand in a corner of the room. Nobody refused as felt the situation would deteriorate. Terence refused us entry into his home, didn't want an outpatient appointment to be arranged or attend an appointment at the Taylor Centre. June had a bag of medication and it appears he hasn't been concordant with medication for a couple of months. He is alluding to there being a dark force which mental health services are involved in but are unaware and therefore he would be at risk if contact is maintained. He would prefer not to leave his flat as he is at risk."

56. At page 448 of the combined records, the MHA examination and admission summary form notes that Terry had *"…refused to engage in conversation about his current mental state – says he was taken from his home without being informed that he is under a Section and was not read his rights.*

57. *Section paperwork states 4 weeks change in mental health state – concerns raised by community mental health team and family. His family report he has paranoid delusions about a paedophilia cult who are very powerful. He believed that this cult was watching him. He was refusing to engage with community mental health services."*

58. At page 449 of the combined records, the MHA examination and admission summary form goes on to note that Terry *"…first sat down and refused to engage and began pacing the room. Agitated…Delusional thoughts, mentions those around him are part of a game and are speaking through headsets. Insight: Does not understand he is unwell."* It was noted also that Terry's provisional diagnosis was *"…Schizophrenia…"* The family were not aware of this diagnosis.

59. As a family we were not present during this assessment, that led to Terry's section. However, we were aware that Terry was to be sectioned under section 2 of the MHA.

Admission

60. As I have explained above, Terry was sectioned on three separate occasions when he became mentally unwell. On all occasions, Terry displayed the following symptoms:

    - False beliefs about things going on in the world, which made him believe he was being persecuted or that he had special abilities.

- Sensing things that weren't there, such as hearing voices or seeing things that other people did not.
- Difficulty organising his thoughts and speaking to the voices in his head.
- Unpredictable and inappropriate behaviour, that at times felt unsafe for him.
- He showed signs of depression, including feelings of sadness, hopelessness, loss of interest in activities. He was also observed to have low energy.
- He could show symptoms of manic behaviour such as elevated mood, increased energy, racing thoughts, impulsive behaviour, and grandiosity.
- He would also withdraw socially and had extreme difficulty functioning appropriately in social situations.

61. On all three occasions that Terry was sectioned, at the time of sectioning, he was admitted to hospital. We do not recall there being any delay in admitting him to hospital, except for the last time in which he should have been sectioned for his own safety and wellbeing in April 2018, which ultimately led to his death.

April 2015 section (s3. MHA)

62. When Terry was sectioned in April 2015, for 28 days, he became violent and needed a secure unit. Unfortunately, they had no beds for Terry locally. Therefore, Terry was transferred to Northampton hospital in the back of a secure van (like a cage). He stayed there for approximately a week and then was moved back to Basildon hospital.

December 2016 (s2. MHA)

63. On 01 December 2016, Terry was admitted to Hadleigh Unit, PICU in Basildon hospital, under section 2 of the MHA, after attending A&E due to presenting with florid psychotic symptoms and paranoid delusions. Terry was an inpatient for 28 days, prior to being discharged. During his inpatient stay, on 07 December 2016, he was transferred to Rochford Hospital and thereafter, on 19 December 2016, he was transferred to Cedar ward after agreeing to informal treatment.

October 2017 (s2. MHA)

64. On 25 October 2017, Terry was admitted to hospital under section 2 of the MHA, again presenting with florid psychotic symptoms and paranoid delusions, after refusing informal admission.

65. On 13 November 2017, Terry was discharged from Section 2 of the Mental Health Act after agreeing to informal treatment.

66. When we went to collect Terry from hospital on this occasion, following his discharge, it was very obvious to see that he was still very unwell. We felt that Terry shouldn't be leaving the hospital and questioned the decision to discharge, with the hospital staff. They told him that he was able to go home which was in our strong view, the totally wrong decision as Terry was displaying a lot of the symptoms mentions above, such as false beliefs, difficulties organising his thoughts, speaking to voices in his head and the unpredictability and inappropriate behaviour, that were unsafe for him.

Ward Environment

Basildon hospital

67. When we went to visit Terry in hospital at Basildon, it felt as though we were all visiting a prison during his first section in 2015. We were locked in a room together whilst visiting Terry, with a window so that staff could see us. It was an awful place and there was no care or compassions shown to any of us during these visits. You were left to just get on with it.

68. Basildon hospital had no outside space and all day whilst visiting Terry, was spent under artificial lighting. As far as we were aware, Terry was never afforded any fresh air during his time in Basildon hospital. This in itself, is not good for anybody's wellbeing, let alone someone suffering with mental health issues, who requires an environment conducive to improving their mental health.

Rochford Hospital

69. Rochford hospital wasn't any better than Basildon hospital for inpatients, in our opinion. We felt that staff were not interested in us at all and went through the motions of letting

us in to visit Terry and seeing us out. Again, there was no care or compassion shown during any of our visits.

70. Rochford was very small, with a paved outside area that held a couple of chairs to sit in. Although this enabled access to daylight for Terry and/or other inpatients, there was just enough room to sit or stand, but not enough room to walk around for exercise and/or strolling purposes.

General observations about ward environment

71. It is shocking that families are treated this way during these distressing times. It is no wonder that Terry never seemed to recover from his time spent in these hospitals under section. We genuinely feel that these times Terry spent on the wards mentioned, added to his trauma and mental health issues.

72. During all visits and communication (or lack of it) with staff we felt helpless and our questions about Terry's care were never fully answered or they couldn't tell us in any particular detail, due to patient confidentiality. This was detrimental to Terry's recovery as we felt that we were never fully able to support him.

73. We know that Terry never liked being in hospital, and that he spent a lot of time in his room, on his own. We are quite sure that Terry's diet was not catered for, especially given that he had Coeliac's disease. As far as we are aware, Terry never mixed with other inpatients or engaged in any activities, which could have improved his mental health.

74. Additionally, the consultant who oversaw Terry's care **Consultant Psychiatrist 2** **[I/S]**, in charge of Terry's care in 2017, generally came across as cold and indifferent, making Terry and my family feel as though Terry was an inconvenience rather than a priority. She would interrupt and talk over us, showing little to no interest in what we had to say concerning Terry's ongoing care and inpatient stay. In our view, she had her own agenda and this was all she was interested in. She would brush us off with short, impersonal responses, making it clear that she didn't value Terry's input. She had an idea of what she thought of Terry (because he was mentally unwell) but she never took the time to know the 'real' Terry and wasn't interested in getting to know and/or understand him. The consultant had already formed an incorrect judgment,

which was very wrong and upsetting to hear. Roy on occasions corrected the consultant on her opinions, although we think these corrections fell on deaf ears.

75. I recall that she had an arrogant attitude, and it was as though she already knew everything, without truly considering Terry's perspective. We are certain that this made Terry feel unworthy, as well as being detrimental to his overall well-being. This lack of empathy and respect for Terry, and his family, created an environment where we all felt ignored, and anxious about Terry's ongoing well-being as an inpatient under section. This also added to Terry's lack of engagement with the doctor.

Staffing Arrangements, Training and Support

76. Throughout Terry's admissions to hospital, it was consistently apparent that there were never enough staff on the wards to provide meaningful care or supervision. This shortage was obvious to us every time we visited. It was extremely difficult to find someone to speak to if we had questions or concerns, and we were often left to wait for long periods with no one coming to check on us or Terry.

77. During visits, we were largely left on our own, without staff offering any guidance, support, or even simple reassurance. This made every visit feel uncomfortable and isolating, as though we were intruding rather than being welcomed as family members trying to support Terry.

78. At Rochford Hospital in particular, we recall staff often sitting together in the office, which was visible through a large glass window looking onto the ward. From our perspective, they appeared to spend most of their time inside that office rather than engaging with patients on the ward itself. The atmosphere felt as though staff were detached and inaccessible, rather than being present and approachable. It was intimidating to have to knock on the office door to ask anything, and sometimes staff would seem reluctant or too busy to come out and speak with us.

79. This apparent understaffing meant that Terry was frequently left on his own, without encouragement to participate in any activities or social interaction that could have helped his mood and recovery. It also meant that practical aspects of his care, such as ensuring his special dietary needs for Coeliac disease were met, didn't seem to receive the consistent attention they required.

80. The shortage of staff had a direct impact on communication too. Questions about Terry's care plans, medication, or progress were often unanswered, brushed aside, or met with vague responses because no one seemed to have the time to speak properly with us. When staff did respond, it sometimes felt rushed, as though they needed to get back to other tasks, which left us feeling like an inconvenience rather than valued contributors to Terry's care.

81. There was also little evidence of therapeutic engagement on the wards. Terry rarely, if ever, mentioned taking part in structured activities, therapy groups, or even informal interactions designed to lift patients' spirits. The lack of staff visible on the ward likely contributed to this absence of stimulation and support, leaving Terry isolated and unoccupied for much of the day.

82. Overall, the persistent lack of adequate staffing created an environment that felt unwelcoming, uncaring, and poorly supervised. It denied Terry the benefit of regular human connection and therapeutic engagement that are essential for mental health recovery. It also left us, as his family, feeling powerless and excluded, unable to get the information or reassurance we desperately needed about Terry's wellbeing.

83. We firmly believe that this chronic shortfall in staffing did not just affect our experience as visitors but had a deeply damaging impact on Terry's mental and emotional health, his sense of safety on the ward, and ultimately his prospects for recovery.

Care Management and Plans

84. As Terry was an adult, we were rarely consulted or meaningfully included in discussions about his care. We accept that Terry was an adult and that the hospital had to respect his confidentiality and wishes. However, Terry was also vulnerable, often very unwell, and not always able to advocate for himself effectively. Despite this, we were almost never invited to care planning meetings, nor were we asked for our views on what Terry might need or what had helped him in the past, which makes it difficult for us and for the families to know what is going on and how to further help their vulnerable family members.

85. Based on the above, we are unaware whether whilst Terry was an inpatient, during each period he spent in hospital, whether he was ever, meaningfully involved in planning his own care. And therefore, we cannot comment as to whether staff actively

engaged Terry in discussions about what would help him feel better, what sort of support he might benefit from, or what his personal wishes and preferences were. Additionally, we are not aware, whilst Terry was an inpatient, as to whether any meetings about Terry's care took place, and whether they were held with his input and/or whether his views were given any real weight.

86. We firmly believe that the level of involvement we had was inadequate and inappropriate. Families often know their family member best, including their history, triggers, what helps, and what makes things worse. If staff had made more effort to involve us, they could have benefited from this insight and built a care plan that was more tailored to Terry as an individual, rather than seeing him only through the narrow lens of his diagnosis.

87. What should have been done differently is, in our view, very straightforward:

- The family should have been properly invited to take part in discussions about Terry's care, to help support him express his views if he found this difficult.

- We should have been invited, wherever appropriate, to meetings where his care was discussed, or at the very least kept informed about what the care plan involved and how Terry was responding.

88. Having considered Terry's medical records, our main concerns are that there does not appear to be any records of treatment / care plans relating to Terry's care whilst he was an inpatient under section. Therefore, we would request that the inquiry team investigate and locate all care plans for us to consider.

Treatment

89. Terry was prescribed medication to help with his mental health symptoms. I understand from having considered his medical records, that the medication he was prescribed for his mental health issues was Olanzapine. Additionally, on page 455 of the combined records, it notes that when Terry was *"…discharged on 13/11/17…"* he was *"…advised he would need to take medication for 2 years"* and would have *"…good prognosis if…compliant with medication…"*

90. It's difficult for us to know if he took this medication regularly or not at all times. Terry told us, and the hospital staff, that the medication made him drowsy and foggy headed which impacted significantly on his daily life. We feel that nobody listened to his concerns about his medication which resulted in him not always taking it and being concordant.

91. As already stated, we feel that Terry should not have been allowed to leave the hospital at the end of his section in October 2017, as it was very obvious that he was still extremely unwell.

Safety

92. As far as we are aware, Terry was not subjected to any direct physical or verbal abuse by staff during his time in hospital. However, we do know that, at times, he did not feel safe while he was there.

93. This sense of feeling unsafe seemed to come from a number of factors. Firstly, the behaviour of other patients could at times be unpredictable, loud, or aggressive, which understandably made Terry anxious and unsettled. From what Terry shared with us, there appeared to be limited supervision on the wards to manage such situations promptly or to reassure more vulnerable patients like Terry when incidents occurred.

94. Secondly, the general atmosphere within the mental health unit felt tense and unsettling, rather than calm and therapeutic. The ward environment often seemed chaotic, with shouting or disturbances, and little visible staff presence to provide a sense of order and safety. Terry was a gentle and reserved person by nature, and such an environment likely had a significant negative impact on his sense of security and wellbeing. One time when Terry's sister visited Terry, a man kept approaching us which was very unsettling. Terry kept telling him to go away and but he kept coming back. In the end, Terry cut the visit short as he was worried about his sister's safety. Terry was very agitated by this incident.

95. Terry's time spent mostly alone in his room, due to the poor ward environments, combined with limited staff engagement and the intimidating atmosphere of the ward, likely increased his sense of vulnerability.

96. Overall, while Terry was not directly abused, the lack of a consistently safe, calm, and well-supervised environment most likely contributed to his distress and made him feel unsafe during what was already an extremely difficult period in his life.

Leave, Absconsion and Awol patients

97. Terry never requested leave but thought that he shouldn't be in the unit, so he always contested all of his sections through the advocacy route. This was never successful.

Transfer

98. As far as we are aware and based upon his medical records, Terry was transferred on a number of occasions, for various reasons, whilst an inpatient.

99. Firstly, Terry was sectioned in April 2015 under s3 of the MHA, as there were no beds for him locally, he was transferred to Northampton hospital where he stayed for approximately a week, prior to being transferred locally to Basildon hospital.

100. Secondly, on 07 December 2016, Terry was transferred to Rochford Hospital, prior to being transferred to Cedar ward on 19 December 2016, after agreeing to informal treatment. I am unaware as to why Terry was transferred as he was on this occasion.

101. I cannot recall being given any concrete information about any of Terry's transfers, apart from being partially made aware of the reason for his first transfer.

Discharge and Continuity and Treatment in the Community

First section - 2015 section 3 MHA

102. I have considered Terry's medical records and I cannot locate his record of his first discharge from section under the mental health act, when he was sectioned on 04 April 2015. Therefore, I cannot provide detail of when it was that he was officially discharged. I do know however, that as he was sectioned under section 3 and was an inpatient for 28 days, therefore, he would have likely been discharged in and/or around 02 May 2015.

103. In addition to the above, I am unaware what the basis was to discharge Terry, based upon not having access to his discharge from section record. I therefore, request that the inquiry make enquiries to locate the discharge record to understand the basis for his discharge.

Second section – 2016 section 2 MHA

104. Based upon the details of the record of discharge, on page 112 of the combined record, Terry was on Cedar Ward and discharged from section 2 from by [I/S] Consultant Psychiatrist 2 on 19 December 2016, after *"…agreeing to informal treatment…"*.

Third section – 2017 section 2 MHA

105. On 25 October 2017, Terry was placed under Section 2 of the Mental Health Act and, again after agreeing to informal treatment, was discharged from Section on 13 November 2017.

106. As previously mentioned, when Terry was discharged from his section (November 2017) we disagreed with this decision totally. We shared our concerns, but nobody listened to us. This was the start of Terry's downfall until his death in April 2018. He never fully recovered from this episode in October 2017. If he had effective and timely treatment in place they would never have discharged him from this section.

107. Each time Terry has been discharged from hospital, we have seen no paperwork or been involved in any decision making. We are not aware of any discharge plans in place.

108. Terry received some/little community care after his discharge from his October 2017 section. However, they signed him off weeks before he died. This demonstrates that they were not aware of Terry's needs and how unwell he was.

109. He should never have been signed off from the care of the mental health team.

Engagement

110. Terry wasn't that involved in decision making about his care. Terry was *'told'* what his treatment was which led to frustration, feeling under valued and not cared for.

111. During his sections, there were set visiting times which we attended regularly. Terry could only contact us through the mental health unit's office telephone. This was frustrating for him as he had to wait for the staff to say when it was convenient for him to use the phone. We would have liked to be able to contact Terry more often than we did. It was always a long process contacting the wards. A lot of the time the phone would ring and nobody would answer it or when they did answer it, they had no time to help you.

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

112. We never received any information about who to contact if we had any concerns.

113. We verbally raised concerns about the following:

- Terry being discharged from hospital in 2017, when he was still clearly unwell
- The difficulty in communicating with and contacting the mental health team i.e. never answering the phone, never returning calls, never giving the information provided and the lack of professionalism by some of their staff. This communication was mainly with the Taylor Centre in Southend and the mental health units when Terry was in hospital.
- The lack of timely responses from the mental health team
- The lack of timely support when Terry was unwell and we knew he needed to go into hospital
- The rudeness of the consultant as explained previously

114. We never received any feedback regarding our concerns.

After Terry's death

115. We were informed of Terry's death by the police. They came to our house to inform us. We also received a call the following morning from a member of staff at The Taylor Centre. His manner was very unprofessional, and he started the conversation with *"have you heard about Terry?"*. He also said **CC's** *in bits"*. **CC** is a

member of staff for EPUT. His manner shocked us and lacked any care or compassion and caused us extreme distress. This member of staff was also the person who lacked cared and attention in Terry's case, in the days leading up to his death.

116. We were offered a Family Liaison Officer, from the mental health team. She caused my family more upset, as her approach was very formal. She came across as though she was merely dealing with a tick box exercise. She lacked empathy for us in this situation and her use of language and conversational skills wasn't fit for purpose. She was meant to visit us again but she didn't and we never chased this as she provided no support at all.

117. The police asked us to identify Terry's body. They didn't know that we had already done this. This again, caused us unnecessary upset. There was an obvious breakdown in communication between the professional agencies.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

118. EPUT did an independent investigation into Terry's death. This was the Root Cause Analysis (RCI) report. You will see evidence documents included in paperwork together with evidence requesting our amendments to the report. The initial report demonstrates their inability to get things right which left us very frustrated at the time. Also, during our initial meeting with the investigating team, we shared all of our notes. They asked for copies, and these were all in the report. We wish we never gave them our notes as the report didn't tell us much more than we already knew. We do feel that they were covering their colleagues backs in this case. We didn't want excuses but wanted answers. We often wonder if their findings have ever been addressed, as we have had no feedback since.

119. For context the RCI report noted our concerns into Terry's death, as follows:

120. *"…the family raised a few concerns which were further investigated. They felt that Mr X (Terry) had not fully recovered since his last hospital admission in October 2017 in that, his perceptual thinking had changed significantly, after this period. They felt that he had never regained his level of functioning as he became more withdrawn, isolated and not wanting to accept any help. They also questioned the medication that he was taking and did not feel it was effective, they described him as feeling fearful and paranoid after discharge from hospital. The family also felt that the cyclical pattern*

of Mr X's (Terry's) relapse was not looked at, neither the deterioration in his social functioning over the years.

121. *Other concerns voiced by the family include:*

- *Communication between the AMHP, the RWB team and the family were poor.*
- *The Team Lead was unprofessional in his communication with the family.*
- *Family felt unsupported during the week end and did not know where to turn to for help."*

122. The RCI also details contact that was made with EPUT services in the aftermath of Terry's passing noting that *"...On Tuesday the 17th April,* **Terry's sister reported** *that she received a telephone call from* **RWB TL** *in the morning and he opened the conversation by stating "Have you heard what happened to T" She said he then went on to tell her that* **CC** *"was in bits", that they now had Mr X's warrant and that the MHA was organised to take place on Wednesday 18th April @ 10.30.* **Terry's sister felt that it** *was inappropriate to share this information with the family, hours after Mr x had passed away, as by this time it was too late. She also felt that* **RWB TL** *overall comments were insensitive and described his attitude as unprofessional.*

123. *In addition, the family expressed that they felt that Mr X had been very badly let down by the local services and that there were mistakes made on Thursday the 12th April in relation to obtaining the warrant. They also added that there was a lack of communication from the team, after the case was handed over from* **CC** *to* **RWB TL** *on Wednesday 11h April. They felt that this contributed to Mr X not receiving the timely care that he so desperately needed. During further investigation following the family's expressed concerns,* **RWB TL** *confirmed that he was contacted by* **Terry's sister on the Thursday** *and the Friday. He accepted the family's comments and stated that after the incident he could have managed the initial contact with the family using more appropriate wording. He said he has reflected on this and sincerely apologises for any additional distress caused to the family, during his interaction with them, but it was certainly not his intention to do so. Further he has offered to send an official apology to the family by way of a letter and also offer them an opportunity for a face to face meeting to facilitate this, if needed."*

124. The above speaks to what we as a family have mentioned earlier in my statement, as to how appallingly we were treated by EPUT when Terry passed, in the

lack of empathy we received and also notes how we have felt about the poor care Terry received.

125. The RCI report, also addressed care and delivery issues, noting the following:

- *The care and delivery problems all attribute to the delay with obtaining the warrant, which was caused by human error in that, the AMHP mistakenly, booked a date that had already passed.*
- *The electronic booking system at the court was faulty, as it should not have allowed the AMHP to book an expired date.*
- *There was no further communication from the AMHP service to the RWB or the family, to alert them of the cause for the delay and provide an update as to when the warrant was likely to be executed. Also to ascertain if the delay is likely to pose a further risk to Mr X, in terms of a risk to himself.*
- *The team only became aware of the above, after* **Terry's sister contacted the service on the** *Friday, enquiring as to why the section had not taken place, when she was informed by the CC That the warrant would be obtained on the Thursday.*
- *The Team Lead then contacted the AMHP for an update and informed* **Terry's sister of the** *delay, but initially the information provided to her did not explain the real cause for the delay with the warrant.*
- *After the case was handed over to the team lead by the CC to oversee in her absence, this did not appear to have occurred as there was no one in communication with the family until Ms made contact with the team.*
- *The family were not given definitive advice as to how they can access support services over the week end, if they had further concerns about Mr X. Hence they reported of feeling let lown and abandoned by the services.*
- *The AMHP service did not follow the case alert system as stated in their operational policy, to alert the EDS of the pending case (MR X), at close of business on Friday afternoon, so that they are aware of the case, if MR X had deteriorated over the week end.*
- *The CRHTT, was considered after the initial assessment by the CC, but was not included in the contingency plan to support the family outside of office hours, whilst waiting for the section to take place. This was primarily due to Mr X's presentation and the risk of aggression towards others.*

126. The RCI report also discusses the system factors that contributed to Terry's passing, with EPUT commenting that there was "…*no apparent system failures in*

regard to the care that Mr X received prior to the incident, except for the court electronic system that resulted in the booking error and the delay of the warrant. The CC responded promptly and appropriately to the expressed concerns by **Terry's sister by** *conducting a home visit the following day, when she returned to work. She also discussed the case at the MDT and informed the Consultant of the outcome of her visit and the action taken, which was agreed".*

127. As a family, we feel that EPUT have not placed significant weight on the system failures, and have dismissed lightly, the impact the failure of their electronic system and the delay in obtaining a warrant had on the outcome of Terry's death. The downplaying of the same, clearly shows that EPUT even at the point of investigating still did not understand the gravity of their actions, and how their errors and poor care was preventable in the death of our Terry.

128. Though, EPUT did not go far enough in the root cause, there was an acknowledgement that they did play a direct role in Terry's death, concluding that *"…if there was no delay with the execution of the AMHP warrant, his death may have been prevented, this would have been dependant on successful detention of the patient.*

129. *The family conclude that Mr X's action was more likely to be a response to a psychotic phenomenon, rather than an intention to take his own life. The investigation considered this to be a reasonable summation, given Mr X's psychiatric history and the associated delusional thoughts, which he expressed in the past, in relation to him being "sacrificed to rid the world of sin."*

130. The RCI report detailed lessons to be learned and recommendations, which included the following:

- There is an electronic fault on the court booking system which needs to be corrected, so as not to allow an expired booking.
- An emergency warrant should have been considered, given Mr X's level of deterioration, which posed a secondary risk to himself. Historical risk factors should be considered for AMHP assessments, in addition to the presenting risks on the day of assessment.
- At close of business on Friday afternoon, all pending MHA assessments should be routinely handed over to the EDS, as a case alert,

- Contingency plan to support the patient and family whilst awaiting for MHA to take place, should be routinely considered by the care team. in case emergency intervention may be needed over the week end

131. The Recommendations are as follows:

- Reinforce alerts to EDS on Friday afternoon (handover re what is outstanding for AMHP hub in Southend). AMHip hub coordinators to action this.
- AMHP hub to have more active role in keeping referrer informed of progress of applying for warrant, coordination of assessment. AMHP hub to record this on MOBIUS.
- The case to be discussed at the EPUT Emergency liaison service meeting for lessons learned; Essex Police, British Transport Police, Inpatient service and AMHP leads present.
- AMHP service to review time frame for applying for a warrant (normally 48 hours) to run alongside arrangements made with Essex police. AMHP hub to alert police at start of warrant application when slot is booked.
- Revisit AMHP hub operational policy for EPUT.
- Feedback to court authority re human error in booking slot for time frame which has already passed. To consider blocking past slots out.
- For the CMHT to ensure that there is continued communication from the team to the family about the progress of an AMHP referral and also ensure that there is someone assigned to oversee this process to completion, if the allocated care coordinator is off duty. This could be delivered by way of a contingency crisis
- support plan, for all AMHP referrals which are likely to be delayed for a MHA.
- One off teaching session to be delivered by Consultant Psychotherapist to the RWB team, Re: How to deliver sad news to families or carers.
- Senior Manager to hold formal supervision and monitoring of practice following concerns raised on RWB TL

Other investigations

132. We are not aware of any other investigations, other than the inquest into Terry's death.

133. The inquest into Terry's death, took place before her majesty's coroner, Mrs Eleanor McGann on 26th September 2018.

134. The coroner following an investigation commenced on 25th April 2018 and an inquest hearing at Essex coroner's court on the 26th September 2018, found that Terry's medical cause of death 1(a) multiple injuries and how, when and where he came by his death, which was that Terry died on 16th April 2018, at his home address due to multiple injuries, with her conclusion as to his death being an open conclusion.

135. The coroner during the inquest, commented that the evidence before her, did not disclose that Terry had an intention to take his own life, as he had been hearing voices in the past, he was frightened of the dark, the nights coming, its sunset and was maybe escaping from something, that we will never know. But that she was not convinced that he would have deliberately killed himself, especially with his son who he obviously adored about to take his GCSEs, as he would have known that he would have ruined his son's life. Therefore, he would never have done that and of furthermore, Terry did not leave any suicide notes to anyone, he didn't leave a note for his son either and therefore, she took the decision, that she was not returning a verdict of suicide.

136. Additionally, and important for us as a family, the coroner, acknowledged it was quite clear that the mental health services had accepted that there were other things they should have done, in particular involving our family in Terry's care.

My views / reflections

137. I think we have shared all of our views in this witness statement and in our commemorative account. Further details of our views also exist in the disclosure noted in my statement and which is available to the inquiry, if necessary.

Recommendations for Change

138. We strongly believe that families should have a far more meaningful and structured involvement in the care and treatment planning of their loved ones. Families often hold vital information about the patient's history, early warning signs, and what approaches are most likely to help. Yet too often, their voices are overlooked.

Embedding family involvement as a routine and integral part of care planning would ensure decisions are better informed and truly centred around the patient's needs.

139. In addition, there must be a significant improvement in communication between mental health professionals, patients, and families. Information should be shared proactively and clearly, with regular updates about the patient's condition, treatment options, and any changes in risk or care plans. This transparency would reduce misunderstandings and foster greater trust between all parties involved.

140. Timely intervention is also critical. Delays in assessing, diagnosing, and treating patients can have devastating consequences. There needs to be an emphasis on reducing waiting times and ensuring that support is offered promptly at the first signs of deterioration, rather than waiting until a crisis point is reached.

141. Finally, it is essential that staff genuinely listen to, and act upon, the views and concerns of both patients and their families. Patients and those closest to them are often the first to notice subtle changes or signs of distress. Taking these concerns seriously could help prevent further harm and, in some cases, may be the difference between life and death.

Statement of Truth

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

Signed: **[I/S]**

Full Name: **June Dicks**

Dated: **12/12/2025**

List of Documents

I attach the following list of documents

- Root Cause Analysis Investigation Report
- Addendum to Root Cause Analysis Report
- Post Mortem Examination Report
- Toxicology Report
- EPUT Medical Records (Mobius)
- Chronology
- Transcript of Inquest Conclusion
- Letter of Response in Civil Case
- Settlement Agreement in Civil Case
- Letter of Apology from EPUT
- Inquest Witness Statement by [I/S] Police in Duty
- Inquest Witness Statement by [I/S] Ambulance Service
- Inquest Witness Statement by [I/S] (Terry's Son)
- Inquest Witness Statement by [I/S] (Terry's Older Sister)
- Inquest Witness Statement by June and Roy Dicks
- Timeline of Calls between 9th to 17th April 2018
- Email Correspondence between Family and EPUT regarding Terry's between 11th to 19th April 2018
- Email from [I/S] Southend CMHT dated 3rd July 2018
- Letters from EPUT