

LAMPARD INQUIRY

WITNESS STATEMENT OF MS SAMANTHA COOK

I, **MS SAMANTHA COOK**, date of birth: [I/S] [I/S] will say as follows:

1. I make this statement pursuant to a Rule 9 request for evidence received from the Lampard Inquiry dated 10 April 2025, in relation to the treatment provided to my late sister, Paula Parretti, whilst under the care of Essex Partnership University NHS Foundation Trust ('EPUT'). Paula was born on 16 May 1975, and passed away on 6 January 2022, aged 46.
2. This statement is made from my own memory of events, knowledge and belief. I have had sight of one document provided to me by the Inquiry Team, which is EPUT's After Action Review (AAR) report dated 3 February 2022, I also have a few documents that I personally kept following Paula's passing and a copy of the inquest bundle from Paula's inquest which was provided to me through my solicitors by Essex's Coroner's office. To further assist with my recollection of the events, I made a request to EPUT directly for medical records which I have not yet received. I wish to put the Inquiry on notice that once I am in receipt of these records, I may wish to provide further evidence to support my statement and would like to reserve my right to do so.

Background

3. Paula and I had a difficult childhood growing up, which I firmly believe is what contributed to the onset of many of her subsequent mental health issues. Paula

witnessed traumatic events

4.

[I/S]

5. My sister began struggling with her mental health at a very young age. According to her postmortem, she started self-harming in 1985, when she was just 10 years old. This continued throughout her teenage years, during which she frequently experienced meltdowns and outbursts both at home and at school.
6. Her difficulties became so severe that, when it was time for me to move from primary to secondary school, our mum did not want us attending the same school. Paula had caused so much conflict there that our mum was worried her reputation would negatively affect me.
7. At 16, Paula moved out of the family home. She and our mum would argue a lot about her explosive temper and so eventually Paula decided to leave.

Early admissions

8. Our mum did try to get Paula mental health support whilst she was in school, I was still young at that time so I do not remember all of the admissions, my mum also [I/S] is not able to assist me.
9. However, I believe Paula started at the Bethlem Maudsley when she was around 16 years old, in 1991. There she witnessed what she said was an extreme amount of self-harm including a woman who had cut off her own breast. Paula's experience there caused her to suffer PTSD. Thereafter, she spent time in the Linden centre when she was around 17/18 years old, and from that point onwards she was in and out of the Linden Centre every 6 months until approximately 2009 when she was aged 34. At 34 years old, she finally started her depo injections which were the only thing that seemed to make her better, before this she would constantly self-harm by cutting her wrists and overdosing. She still spent more time in the Linden Centre from that point too but less frequently than before.
10. Paula suffered with her mental health for the majority of her life so there are likely admissions in the last 20 years of her life that I cannot immediately recall and would need her EPUT records in order to assist me.

Linden Centre

11. For the avoidance of doubt, unless otherwise stated with specific dates, the reflections I make below relate to the times and events I can remember which are all from Paula's later years when both her and I were adults. The matters discussed are therefore relevant as they relate to the time period being investigated by this inquiry.

Paula's complaints

12. Paula could not stand the Linden Centre; she would always tell me how awful she would be treated. She would go in wanting help, wanting a bit of mental stability but would always be treated "less than human".
13. She would often complain that she was not given medication on time and would be made to wait for it. The wait could then be even longer when staff were not calling or checking in as regularly.
14. Throughout the years, visitation policies also changed. I did visit Paula occasionally, but she had a friend and another lifelong friend that visited her more often.
15. At first, visitors were able to go to the patient's room during visits but that later changed to visitors being restricted to the dayroom only. It was obvious they were short staffed and could not manage the number of patient's being treated. Paula at one point had to share a room with another patient and that definitely made her feel uncomfortable. As a result, she became more possessive about her belongings.

Incident where Paula was severely injured

16. For the purposes of this inquiry, I do remember one occasion that is important to recount of Paula's experience at the Linden centre following which she sustained quite serious physical injuries at the hands of staff members. I have since discussed the incident with Paula's best friend, Hannah who was also around at the time.
17. This occurred in October 2012 when Paula was 37 years old. On 15 October 2012, Paula told Hannah that she was hallucinating and feeling strange. According to Hannah, Paula was not showing any signs of aggressive behaviour, she was just frightened about the hallucinations she was experiencing. Hannah called the Linden

- Centre and they had told her to bring Paula in to be seen, which she did with her mum, Ed.
18. They were met with some hostility when they first arrived. Paula had to hand over her property and when someone who worked there took a hold of her bag, she asked if she could first have her headphones from the bag and they told her she was not allowed them, Paula then either raised her voice or reached into her pocket and the alarm was raised. This caused about 10 staff members to swarm through the door and tackle Paula to the ground, along with Hannah who tried to intervene to help her. Ed, who had been suffering with a serious medical condition was watching and started struggling to breathe.
 19. As Paula was being tackled and restrained, a staff member put so much pressure on her leg that it caused a tennis ball sized lump to immediately form. Hannah says that later that day a doctor looked at Paula's leg, which was by this point huge and swollen, and advised that she would need an ultrasound.
 20. Nobody from the Linden Centre took her to the hospital that day. In fact, it was 4 days later, on 19 October 2012, that Paula was taken to A&E where she spent 8 hours just to ultimately be told that it was a bruise and she was quickly discharged back to the Linden Centre.
 21. The next day, on 20 October 2012, Paula approached a member of staff to say she felt a 'pop' in her leg. She was told to sit down in the lounge and that made her feel 'silly' for even mentioning it.
 22. Then on 24 October 2012, 4 days later, there was a ward review, Paula's injury was assessed again by the team doctor and that day she was immediately admitted to A&E for an operation.
 23. Mum and I went to visit Paula after that and she was completely traumatised. She said *"I told you that they treat you like rubbish in here!"* She explained to us that she had been attacked by staff and complained that they had no compassion or care for the patients there.
 24. Whether it was her that had an outburst or not, it should not have resulted in her sustaining severe injuries, not when she was supposed to be in the care of professionals and having treatment, and furthermore, it should not have taken them 4 days to assess her injury and a further 5 days before she was able to have a much

needed operation. The treatment, the dismissing of my sister's concerns and the delays were totally unacceptable.

25. I am not sure who lodged a complaint on her behalf after this incident but the Linden Centre did accept responsibility and Paula was paid £200 in compensation.

Diagnosis

26. Paula was diagnosed with Borderline Personality Disorder ('BPD') in 2004 at the age of 29. According to her postmortem and GP records, she had not been diagnosed with any mental health condition before this date. However, I do believe her issues started much earlier than this, especially considering she was only 10 when she first started self-harming.

27. Within a few years of this diagnosis, i.e. in the early 2000s, she started taking drugs and this developed slowly into an addiction. By the time of her death, she had been addicted to cocaine for about 20 years.

28. During the earlier part of her addiction, she did manage to have some stability. In fact, my experience of my sister was that, from that early period up until 2021 she was doing okay, managing the addiction but still functioning. There were times when I had to stop being around her so much because of relapses and/or nasty behaviour but for the most part she was okay and we were really close. She got some help for her mental health and started to understand how her outbursts were affecting me and our relationship. We had a routine where I would sometimes pick her up on my way home from my job and we would go out and spend quality time together which made her really happy. She was also a brilliant aunt to my kids. They loved her very much when she was around.

29. I was happy she was doing much better, but, whilst that is the version of my sister I was seeing on a daily basis, I am aware now and based on my reading of her records after the fact, that there were instances of her overdosing in that period too. For example, the following events are recorded in the postmortem:

- a. Drug overdose (2009)
- b. Drug overdose (February 2017)
- c. Drug overdose May 2019)
- d. Drug overdose (January 2020)

- e. Drug Overdose (June 2021)
- f. Drug overdose (November 2021).

30. Between May 2015 and March 2020, she also reportedly missed 29 scheduled GP appointments and 1 that was “cancelled” when she attended but walked out of the appointment before it finished.

31. Ultimately, she was still not doing well but compared to her teenage years and early 20s, she was much more stable than she had been.

2021

32. Then in 2021, she had a severe decline for the first time in a very long time. I think she felt isolated and this caused her to increase the amount of drugs she was taking.

33. She had a social worker called **Ms A** who she really liked but that eventually changed and then kept changing to the point where she did not even know who her social worker was and had no idea who to call in an emergency. That is when she started regularly calling the Samaritans and they would also call her every day.

34. At one point she had a social worker who was not only useless, she was also condescending and rude; Paula did not like her at all. Her social care had gone from in-person weekly meetings for an hour with **Ms A** to just 10 minutes every two weeks when she would get her depo injection administered.

35. Paula was also promised drug rehabilitation by the social care team. I am unclear if it was through Open Road Visions (the Drug & Alcohol recovery service) or not, but despite it being offered nobody would help her with the forms, and even after I helped her with them and we submitted them, nothing ever came of it. We did follow it up a few times but would always be told that she just had to wait.

36. I was also dealing with a lot at the time, struggling to balance taking care of my kids, my mum and Paula – it was a lot of pressure on me. I am just so thankful that Paula had Rob and Hannah, both her best friends, that were around to take turns with me to visit, call and check in on Paula on a regular basis. Hannah truly went above and beyond for Paula all their lives and was amazing.

37. We eventually discussed Paula going back into inpatient treatment, she expressed to me how terrified she was at the thought of going back to the Linden Centre but said she was willing to go if it made her better. One thing I know is that she did not want to die, she would say so in her diary – that she had an overwhelming feeling to kill herself but that she did not want to die. She was ready and willing to get help even if it meant going back to the place she was traumatised and injured.

17 November 2021

38. Paula then waited months for a bed and between the social care and Home Treatment Team, nobody seemed to chase it up or put any pressure on her getting a placement as soon as possible.

39. Then on 17 November 2021, Paula took an overdose. She told me as soon as she had taken it, so I called an ambulance and she was taken to Broomfield Hospital A&E. She was checked, they determined it was not a very big overdose and so she was discharged the same day. I met her at her house after she got home.

40. When I saw her, she was a bit drowsy and a little bit depressed. She was also complaining about the neighbours who, because of her paranoia, she thought were coming after her. She was taking more cocaine than usual around this time whilst simultaneously suffering from BPD and waiting desperately and patiently in the community for a bed on a mental health ward so she could get proper treatment.

18 November 2021

41. The next day, on 18 November at 17:00hrs, Paula went to A&E again and was assessed by two clinicians from the mental health liaison team of Broomfield Hospital. Paula asked at that point to be admitted onto a mental health ward. As a result of her asking, she was offered an informal admission, however when they checked, there were no beds either locally or nationally, so she was sent home again and told to wait.

42. I took her home and in the car she was *saying 'nobody wants to help me, nobody cares'*. She also started having suicidal thoughts that night.

19 November 2021

43. On 19 November Paula was reviewed by the Home Treatment Team. Later that day she started feeling unsafe at home because of the suicidal thoughts she had been

having the night before, so she contacted the Samaritans and was asked by them to go to A&E to wait for a bed.

44. She did that and upon arrival she was escorted to the Mental Health Liaison Team Suite. She reported to them that she had been having thoughts of ligaturing herself and jumping out of a moving car. An incident form was completed; she handed over her items of risk and waited for an admission.

22 November 2021

45. Three days later, i.e. by 22 November 2021, Paula was still waiting for an admission and in her frustration about the wait, she asked to be sent home. She was reviewed by 2 clinicians and told them she had been waiting for an admission since 18 November. When asked about suicidal thoughts, she denied having any, so ultimately it was agreed that Paula could return home and a plan was made for her to see the home treatment team instead of having the hospital admission anymore.
46. Paula at this time was a heightened risk patient; she was heavily abusing drugs and had recently been seen in A&E because of a drug overdose. She had expressed having suicidal thoughts only a few days before and had been at the hospital waiting for several days for an admission because she felt severely unwell. Yet the clinicians could not recognise that she was in enough danger that necessitated her staying in hospital to at least be monitored, instead she told them she was fine and they let her discharge herself. Paula had fully given up but it appeared that EPUT had too.
47. On 22 November 2022, I called the hospital to see how she was and I was told she was fine with no mention whatsoever about a discharge. I asked them to please keep her phone away from her as I needed to come and tell her face to face that our uncle had passed away. I expressed to them on the phone that death was a trigger for her and mentioned we had lost a lot of people in a short space of time, so she was not going to take the news well. They assured me they understood.
48. I then dropped my son off and drove to the hospital. Whilst driving, I had a call from them to say they have just discharged her. I asked why and explained the conversation I had had with them 20 minutes previously, but they said it was out of their hands now as she has been discharged already. I got there about 10 minutes later and explained to Paula what happened to our uncle. She started having a panic attack and the doctor walked in and told me (whilst she was mid panic attack,

struggling to breathe) to take her home as they need the beds, as he dropped her bag at my feet.

49. I had to calm her down on my own, and she did calm down, but I became concerned when on the drive back to her house she stayed extremely quiet. She was at this point eerily calm, as if she was numb because she had given up on everything. When I suggested to her that I could drive her back to the hospital if she wanted me to, she simply said there was no point in reaching out for help. She said it felt useless, that she knew only a few of her friends and I cared about her and that she knew she was a burden to us; despite being told how loved she was by us.

50. I knew something was wrong so when we got to her house, I asked her if she wanted to stay at mine instead, but she said she was ok, that it was just that she had not been given her medication.

Home Treatment Team

51. On 6 December 2021, Paula was discharged as an outpatient from the home treatment team, I am not sure why considering she was still not well, but from that point onwards, Paula's friends and I took over her care. She had no more support from any community mental health services from that point onwards.

52. Paula did not do well over that Christmas period. She wanted to spend Christmas alone with her cat, which I let her do because I understood, as much as it is considered a "holiday" for most, Christmas is not always the best time for a lot of people, so they choose not to be around other people, especially when they are suffering with depression or PTSD.

53. Instead, we agreed to spend Boxing Day together. Paula always preferred boxing Day any way. I was to pick her up that day but I was running around 40 minutes late to get her, and in the time I was running late she had got drunk. I told her that she had to pull it together as she was not going to be able to be around the kids in that condition. I got her some coffee and some cheese and she started sobering up with that.

54. Reflecting on it now, I know that something was deeply wrong with her at the time, again because of how completely calm she was. Even in her inebriated condition,

there was no outrage or hysterics, I could not put my finger on it back then but looking back on it now, I fear she was numb and sort of accepting of her fate.

55. Still, she did come over for Boxing Day and we had a nice family time together. For New Years, she spent the time with her friends and from what I recall she had a nice time too.

Paula's death

56. The New Year of 2022 came and went but by the 6th day of the year, our lives changed forever and the image I have of my sister has forever scarred me.

57. I had taken the day off work, which was rare for me, I rarely take leave. I also overslept that day, which is also something I rarely do but I was very tired. I missed a call from Paula, and she had sent a voicemail which I did not immediately listen to either. When I checked my phone, I saw the call and a text that had come in at 06:09am which said something along the lines of, *"GOODBYE FLOWER THANK YOU FOR LETTING ME BE PART OF YOUR FAMILY"*.

58. When I eventually saw it, I was not immediately panicked because this sort of message from Paula was not uncommon. It was only after I had called her back and she did not answer, and texted her and she did not answer, that I started to worry.

59. It was around 4:44pm and I went over to her house with Rob who I had learned had also received a similar text message from Paula. I had a key, so we entered the house and that is when we found her hanging [I/S]

[I/S]

60. This last image of Paula is what I see now whenever I think of her, not any of the fun times we shared or the happy memories I used to have of her. Just how I found my sister on that day.

61. I called 999 and Rob cut her down with a pair of scissors. First the police came and then ambulance workers came. There was a lot of them. I remember there was about 3 or 4 ambulances in the car park. It felt very much as though some of them had attended just for training purposes because many of them were just standing around staring.

62. Paula was pronounced dead at 5:00pm on 6 January 2022.
63. Before the police officers left the property, some of Paula's belongings were taken. I understand that they had found packaging of Paula's medications for example. The medications located were Topiramate 50MG, Zolpidem 10MG, Promethazine Hydrochloride 25MG, Omeprazole 20MG and Fenbid 100g.
64. After the incident, the police also found as part of their investigations, multiple prior calls on their system showing that Paula had repeatedly reported harassment by her neighbours – most of which was investigated at the time. I do remember this ongoing situation, she had been dealing with issues with her neighbours for over two years, reporting the complaints not just to the police but also to her housing association. When the prior calls were brought to my attention by the police officers, I explained that my sister struggled with her mental health for many years, and I believe this chronic struggle compounded her feelings of paranoia and insomnia during that difficult period.

Inquest proceedings

65. The inquest into Paula's death was held on 27 October 2023. The cause of death as confirmed on her interim death certificate is "*Hanging*". The clinicopathological summary outlines the circumstances of death as:

"Post mortem examination on this lady revealed evidence of prominent ligature mark on the neck consistent with hanging. Toxicological analysis showed evidence of recent cocaine use. However, the cause of death in my opinion was due to hanging. Death was not due to natural causes".

66. The inquest lasted all but 45 minutes, we were not legally represented because we did not know we could be. We were never told that that was an option despite having a Family Liaison officer assigned to us. Rob and I attended the inquest in person. I was really unhappy with the way it ran and spoke to our Family Liaison officer about my frustrations after, but she suggested to us that fighting it would be pointless, and so because of her deterrence, we left it alone feeling very deflated.
67. I will always remember that the Coroner at one point tried his best to suggest to us that he knew there were ongoing concerns being raised about EPUT, I recall him

saying something along the lines of “*I cannot tell you what do about the treatment [Paula] received, but if I were you I would be contacting people*”. He seemed very troubled by the fact that he had heard a lot about EPUT and their repeated mistakes and poor-quality care and treatment but knew he could not say something about it outright. He was very professional but the undertones of his serious criticisms were made very clear, as was the fact that he wanted us to know.

Other investigations

68. Following Paula’s passing, EPUT produced an After Action Review (AAR) report, which I have in my possession, and despite everything, the report’s overall language and findings insist repeatedly that there was zero wrongdoing or failure in EPUT’s care of my sister – a conclusion I find deeply shocking and impossible to accept.

69. Specifically, the report says:

*“The group **struggled** to identify any formal actions to take following the AAR. It was felt that reflection of the positive practices of the teams should be considered and that other teams should reflect on their practice with complex clients.’ Further stating that learning would be shared widely throughout the trust by ‘risk management to share learning with community teams across the Trust.’*

70. It goes on to say:

*“it was identified that the team were responding to PP’s fluctuations in mental state appropriately and providing levels of support that were reasonable to the level of risk period. It was difficult to identify learning as the team had followed policy, procedure, **and beyond**. Attempts were made by the team to predict difficulties around medication and how to support PP with this during difficult periods and increasing the level of support as required.*

One thing that was taken away from the AAR meeting was that the team did in fact support PP to the best of their abilities and worked well as a team to manage numerous long-term risk.”

71. They also proudly cover what they say went well in relation to Paula’s care:

- *“Care Coordinator had been in place for last 6 weeks, following PP’s request to change which the team facilitated*
- *The team reacted to her needs as they came up, changed care coordinator, organised urgent medication reviews, provided duty input and weekend support, and PP engaged well with support.*
- *Was being monitored face to face every two weeks for depot, this gave time for Care Coordinator to engaged, and would spend around 60 minutes at each appointment to allow PP time and space to explore her difficulties*
- *Concern of Care Coordinator was that PP was higher risk of overdose or misadventure, hanging was a real shock and surprise. Team had good awareness of PP, her triggers, risk, and difficulties as PP had been under their care for many years, numerous staff knew her well and were able to provide appropriate levels of support through the duty team between her regular appointments with the care coordinator.”*

72. I also received a letter dated 15 March 2022 from EPUT’s Head of Patient Safety Incident Management Team following the AAR, which says categorically and in a tone that suggests a doubling down on their original position, **“there are no new opportunities for future learning from Paula’s clinical team or across the Trust”**.

73. To me, the report and that follow-up letter shows a staggering sense of arrogance on the part of the investigators. Not only do they tell me there are *“no opportunities for learning”*, but they further minimize the situation by noting that it was a **“struggle”** to identify any formal actions to take because staff had followed policy, procedure **“and beyond”** in my sister’s case.

74. It may not have been intended to sound that way but it absolutely does – especially when I think about the complaints I raised about my sister’s care. I know for a fact that there were fundamental failures in her care that contributed to her death. Namely, the extensive delays in finding her a bed – *any* bed - on an inpatient ward when she was begging to be admitted because she felt unsafe at home, and of course the most critical failure was discharging her home on 22 November 2022 when she was clearly still not well enough to be left in the community.

My concerns outlined

75. To pick out a few of the concerns with the report, I note the following:

76. The review report says:

"[Paula] Was being monitored face to face every two weeks for depot, this gave time for Care Coordinator to engaged, and would spend around 60 minutes at each appointment to allow PP time and space to explore her difficulties"

77. This is frankly misleading. Paula complained to me multiple times that she was not having face to face meetings with her social worker as often as she needed to. I have already mentioned how her appointments went from regular in-person weekly meetings for an hour with Ms A to just 10-minute sessions every two weeks.

78. I also remember that part of the reason Paula did not like that one particular social worker, was because she kept bringing along trainees to the appointments (or what my sister would call "strange men") that Paula did not know or recognise. She would tell the social worker to please stop bringing the trainees round because she had been sexually abused in the past and it was triggering for her, but they still turned up and it would send Paula spiralling. I even said it to the social worker myself and it still did not change. The general way that particular social worker treated my sister was awful, I was on the phone to Paula, listening in to some of their conversations and I would hear how she would speak, not trauma-informed in the slightest.

79. In addition, I note this point from the review report:

*"Concern of Care Coordinator was that PP was higher risk of overdose or misadventure, **hanging was a real shock and surprise. Team had good awareness of PP, her triggers, risk, and difficulties as PP had been under their care for many years, numerous staff knew her well and were able to provide appropriate levels of support through the duty team between her regular appointments with the care coordinator.**"*

80. This is also repeated in other places in the report too:

*"PP sadly took her life following extensive drug use; **the team felt PP's main risk was around overdose or substance abuse misadventure. The patient has not expressed suicidal ideation by hanging and this came as a shock to the team**"*

81. I would think, as a mental health professional, you would know that if a patient is known to overdose and has been suicidal for many years, it would not be far-fetched for their suicide to come in a different form to pills? Surely you should anticipate that. I note it also refers to “*the team*”, making it clear that it was all of them who could not anticipate that a person with ongoing, years’ long suicidal ideation may not necessarily rule out certain forms of dying if they made the decision to end their life.
82. Even with that in mind, I know from my personal experience with Paula that she *did* mention she would hang herself to me. She also told staff on 19 November 2021 that she had been having thoughts of ligaturing herself and jumping out of the moving car that she had travelled in to get to the hospital. So, there were multiple times where her suicidal ideation was not related to an overdose.
83. This is why it is imperative that this inquiry obtain my sister’s EPUT records as part of the review and understanding of the wider issues relating to poor post-death investigations by EPUT, precisely so that we can see if there were any recorded mentions by my sister, in writing, of alternative ways that she might end her life, which, if found, would prove definitively that it should not have been a total surprise that she chose to hang herself and that this AAR investigation is completely bias.
84. In any event, it would seem to me logical and even necessary for mental health professionals to try to anticipate that patients could end their life in a number of different ways, particularly so you can properly mitigate against the risks, and so you do not end up in the position outlined here, of being “*real[ly] shocked and surprised*” when they do it in a way you were not expecting.
85. To be so wrong about my sister’s risks and then go on to say that the team had “*good awareness*” of her risk, right after admitting that her hanging was a complete surprise to them, is very insulting. Instead, I would have wanted the report to tell me why they think a person who overdoses is unlikely to commit suicide by hanging? Why they had not anticipated this and what learning is available here so that this sort of one-dimensional thinking does not leave another patient in a similarly let down position like my sister was.
86. Furthermore, I would like to include mention of an email that I sent to the Coroner’s office on 21 October 2022 where I raised several of the concerns I had about my

sister's care, which directly contradicts the findings in the AAR report and which have never been addressed in any full or comprehensive way by anybody responsible for investigating whether my sister was failed by EPUT. I raised the following points in that email (which have been added to in this statement for a better understanding):

- a. Why, in the final few months of my sister's life, was she abandoned by the Home Treatment team who discharged her on 6 December 2021 when she was still very clearly unwell?
- b. Why when she took an overdose, was she sent home from hospital the next day, despite repeatedly saying *'if you send me home, I'm going to hang myself'*
- c. Why was she promised rehabilitation for her drug addiction, and given brochures by her social worker and home treatment team for this, and yet nothing came from it ultimately? Which left her stuck and struggling with an addiction she desperately wanted treatment for.
- d. Both myself and others involved repeatedly called the GP, hospital and Paula's social worker warning them that she needed immediate help or she was going to take her own life, and we were always met with the same response; *"there is nowhere for her to go"*.
- e. Then when she was finally assessed in the A&E department of Broomfield hospital on 19 November 2021 and thereafter moved to the Mental Health Liaison Team suite, they left her for 3 days without any of her medication, despite her being prescribed daily medications for her BPD and fractured back.
- f. She was left, after those 3 days, wanting to discharge herself but only because she was so frustrated with waiting in limbo that she thought she would be more comfortable at home, it was not because she felt any better or any safer to be let go. There was no thorough review of that situation, her masking or her suitability to be discharged, they simply let her go, even though she was clearly highly vulnerable.
- g. That day she was discharged; I also spoke to them on the phone and told them to please keep her phone away from her as my uncle had just died and I wanted to tell her face to face, sensitively, as death was a trigger for her, I told them I was on my way that I would arrive within an hour and in that hour, they discharged her.

- h. She then suffered a panic attack on the ward and instead of providing us a room or ushering us to speak somewhere safe, they came and dropped her bags at my feet and told me to take her home.
- i. She expressed on the way home how she still wanted to hang herself. I suggested taking her back but she felt so low and hopeless that she told me there was no point. I witnessed first hand how people there just seem to lack compassion when dealing with people at the most vulnerable time of their lives.

87. Overall, I am outraged by the poor care and treatment offered to my sister in her greatest time of need. In the time she was waiting for a bed, Paula was showing obvious signs that she was not coping in the community, particularly when she is turning up to A&E after taking an overdose and claiming she feels like ligaturing herself and jumping out of a moving car. Each time she showed up, she was sent away. The time that was particularly egregious, on 22 November 2021 ought to be properly investigated because she was sent home without a proper mental health assessment when she was clearly at heightened risk. The fact that the investigation report fails to pick up on any of these issues is a continuation of the harm caused to my sister and my family as a result of her death, and the fact that what is picked up instead, is only the highest of praise by the investigators for EPUT, who were involved in my sister's care over 30 plus years, is frustrating. My sister died waiting for an inpatient bed, and was instead left alone for months without any professional overseeing her care. It demonstrates that the investigation into EPUT's failings was not fit for purpose.

Recommendations for change

88. I have been asked to comment on proposals for change that I think the Chair should consider in order to improve EPUT's services so that more families are not effected by poor care in future. My recommendations are as follows:
- a. Interdisciplinary communication – myself, my family members and Paula's friends spent time calling the GP, hospital and community care team for Paula at different times, and it always seemed that there was no multidisciplinary action being taken. Teams need to be in communication and need to have access to full records and a patient's complete history before making decisions about their care, so as not to miss anything crucial.

- b. Scarcity of inpatient beds – As is outlined in my statement, Paula died waiting for an inpatient bed to be made available. At the time she had relapsed in her cocaine addiction and was begging to be admitted because she wanted care and felt unsafe to be at home. She was telling staff she thought she might kill herself and took herself to A&E on more than one occasion hoping to finally be admitted. She was sent home every time when she needed the help. Bed occupancy rates have been sky high for several years, and it has left many patients suffering because they cannot get the treatment they need. Some, like my sister and others I know, have died waiting for a bed. It is unacceptable, and the scarcity and backlog needs to be urgently addressed.
- c. The need for proper mental health assessments – it is unacceptable to take a patient like my sister, knowing she is waiting to be admitted following a mental health episode and still send her home when she is at significant risk of harming herself. The assessment on 22 November 2021 that they conducted of my sister before discharging her back to the community care team, was abysmal. It was substandard and unprofessional. If it had been thorough, it would have been clear to the medical team that she was unfit to be left alone.

List of documents for the Inquiry to obtain

In APPENDIX 1, I have outlined the documents in my possession that I have specifically referred to/utilised to formulate this rule 9 statement.

Statement of Truth

I believe the content of this statement to be true.

SIGNED [I/S]

MS SAMANTHA COOK

Dated 23 December 2025

WITNESS STATEMENT OF SAMANTHA COOK PURSUANT TO RULE 9 REQUEST
FROM THE LAMPARD INQUIRY

APPENDIX 1 – LIST OF DICUMENTS WHICH I HAVE

Document	Date
After Action Review (AAR) report	03.02.2022
Postmortem report	Undated
Inquest records	28.04.2020
My email to the coroner's office regarding my concerns about my sister's care	21.10.2022
Paula's Interim Death Certificate	11.01.2022