Name of Witness : Amanda Cook
Statement : 1
Date : 09.01.2026

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

1. My brother Glenn Holmes was born on 23/03/1993 and died on 07/07/2012. Glenn was under the care of North Essex Partnership NHS Foundation Trust at the time of his death.

2. I have provided a timeline of events leading up to Glenn's death based on my own recollection and from the disclosure I have.

3. Before I discuss Glenn's mental health, it is important to discuss the environment he grew up in. As is evident from Glenn's medical records, he grew up in a disfunctional household witnessing **traumatic events** **[I/S]** Glenn's childhood was troublesome and his mental health struggles were very much linked to the enviornment he was exposed to when growing up. Our parents divorced when Glenn was around 5. **[I/S]** since then we have not been in contact with our biological father.

4. Glenn's initial contact with mental health services began when he was around 4, when both Glenn and myself were referred to family therapy because of how

traumatic things were at home. Having read Glenn's records, it appears that he was not in contact with the mental health services again until 2009.

Mental health history (2009 – 2012)

2009

5. On 11th November 2009, Glenn was referred to the Child and Adolscent mental health services (CAMHS) by his GP. The reason for this referral is noted to be due to *'depression, self-harm behaviours, morbid thoughts and suicide ideation'*. On 19th November 2009, Glenn was seen by I/S (a behavioural nurse therapist) under the CAMHS community team in Colchester. During this consultation, it is noted that Glenn's *'close friend self-harms'* because of which *'Glenn gets angry at him'* and that at *'age 13, Glenn's friend hanged himself'*. Glenn is also reported to *'having low self-esteem and self worth'*. He also reports to '*usually self-harming at night*' and as having thoughts of *either 'killing himself once a fortnight' or 'stabbing himself, overdosing or drowning'*.

6. He reported having '*severe difficulties*' with emotions, concentration and behaviour. Glenn is noted to have said that these difficulties have been going on for '*over a year*' and that he was highly distressed by this. He is further noted to explain that the difficulties he has mentioned above, impacts his home life, friendships, classroom learning, and leisure activities a '*great deal*'.

7. On 7th December 2009, Glenn was seen by **Dr A** (Speciality doctor in Child & Adolescent Psychiatry). He was seen on his own. Although, he attended the appointment with our mother, he did not want to speak to **Dr A** **[I/S]** in front of her. Glenn reported that he *'had thoughts about choking himself with vodka'* but is noted to have *'denied active suicidal ideation or plan.'* He [Glenn] requested antidepressants as his *'depression and sleep pattern got worse'*. During this consultation Glenn was told that he would be reviewed in a weeks time. There appears to be no discussion of immediate follow up with a phone call or visit, despite Glenn saying that he had thoughts of *'choking himself'*.

8. On 17th December 2009 Glenn was seen by **Dr A** at North Essex Partnership NHS Foundation Trust. During this consultation Glenn *'reported feeling depressed with poor sleep and suicidal ideation with no active plan'*. Glenn *'continued to feel depressed, started self-harming a few days ago....and admitted to taking more Zopiclone (4-5 tablets)'* as he found it difficult to sleep when he had negative thoughts. The next review was booked in for 4th January 2010. My concern here is that Glenn's presentation was clearly alarming and yet an appointment was only given **18 days after** this appointment. Why were no provisions put in place for a phone call or an inperson appointment sooner? The sporadic appointments did not help Glenn at all. The inquiry will note that Glenn self-harms **5 times before his**

appointment with Dr A on 4th January 2010. It seems to me that no consideration is given to stop Glenn from engaging in self harm and no plan seems to be in place to deal with any unpredicatable behaviour from him. This is even more worrying as Glenn was known to the mental health services. His treating clinicians ought to have recongised that there is a high posibility that Glenn may impulsively self- harm again.

2010

9. On 4th January 2010 Glenn was seen again by Dr A. During this consultation Glenn spoke about self-harming 5 times since his last appointment with Dr A. Glenn explained that one of the reasons he did this was because he felt that *'he was making his mum more depressed and anxious because of his behaviour'*. The records note Glenn punching a photo frame and self-harming by cutting his arm with a mirror. Within the same entry however, the records state that *'Glenn denied any active suicidal ideation or plan or intent'*. There seems to be no recognition that self-harm can in fact lead to death. What difference does denying '*active suicide ideation or plan or intent'* make if Glenn is repeatedly engaging in self-harm behaviour? Even if during consultations, there appears to be no 'active' plan for self-harm, there is absolutely no guarantee that a mentally unwell patient with a history of self-harm will refrain from doing so again.

10. On 1st April 2010, a referral is made by the Child and Adolescent psychiatry service to transfer Glenn to the adult psychiatry team as he has now turned 17. **Dr B** (one of the consultants involved in Glenn's care) was of the view that *'he [Glenn] would be better looked after by the adult team'* given *'he is now 17'*.

11. On 28th May 2010, Glenn's GP contacted North Essex Partnership Trust (NEPT) requesting an urgent appointment for him and reported that Glenn had been waiting for an appointment since his discharge from CAMHS. In a letter dated 1st June 2010, Glenn's GP makes a further referral to **Dr C** **[I/S]** (Consultant psychiatrist). The letter states :

Dear **Dr C**

Reason for referral : ***Depression with Self-harm***

This 17 year old Id was recently discharged by CAMHS due to his age. The last letter states that they were referring to your services but he has not yet received an appointment. He continues to suffer from depression and ***intermittently self-harms but superficial cutting****.*

More worryingly he has recently started to overdose on his medication (fluoxetine) and about a month ago drank **a large amount** **[I/S]** *this was followed by GI symptoms for 24 houra.*

He tells me that he had no intent to die and does not think he will do it again, ***but feels he might do so again if he became very frustrated****.*

I have strongly advised him not to overdose. He has the NERIL crisis line number.

I would be grateful for your early assesment please.

Yours sincerely

GP

12. Glenn was next seen by **Dr B** (Consultant Child & Adolescent Psychiatrist) only on 17th June 2010, **16 days after** he reported that he may *'self harm again if he becomes frustrated again'*. I am strongly of the view that an earlier appointment was absolutely vital to understand what was going on in Glenn's mind.

13. During the consultation on 17th June 2010, Glenn reported to have self-harmed by *'using* **medication and** by using *'some sort of solvents to make him feel high'*. I would like to reiterate that the gap between consultations meant that Glenn had opportunities to put himself at a high risk. In terms of

treatment, Glenn was taught *'techniques of DBT to deal with self-cutting, using a rubber band and ketchup when he feels overwhelmed with stress'*. Glenn was also prescribed an increased dose of Fluoxetine as he reported to benefit from this prescription. **Dr B** however gave Glenn a repeat prescription *'on a 2 week basis'* in order '*to safeguard Fluoxetine from being used as an overdose'.* No changes are made to other prescriptions, and Glenn was to continue taking Zopiclone along with Fluoxetine.

14. I understand that Glenn reported benefitting from taking Fluoxetine during the consultation on 17th June 2010. However, given his history of overdosing, it is my view that further care should have been taken when prescribing any form of medication to Glenn. This is because within 24 hours after the consultation on 17th June 2010, Glenn was seen by the crisis team for overdosing on prescribed medication (Zopiclone). Glenn was noted to be presenting as *'confused'* and *disoriented'.* He also reported to be *'seeing worms.'* and to have taken **a quantity** of zopiclone the night before his admission *'just to help him sleep'.* He was yet again assessed as not having any suicidal intention. It was noted that Glenn had '*only taken the tablets to aid him to relax'.*

15. On 19th June 2010, a risk assessment was completed. It was noted that staff were unable to complete a risk assessment on 18th June 2010 due to Glenn appearing *'confused, disorientated and suffering from hallucinations'.* The

agreed plan was for Glenn to go home with my mother who would lock all of his medication away and give him appropriate medication at the right time.

16. Glenn is then seen by a community psyhcaitric nurse (CPN [CPN] in his school on 25th June 2010. Whilst he appeared to be in a *'bright and chatty in mood'*, he reported that he had taken [I/S] *antihistamien tablets last night to get high'*. Alarmingly, during this [consultation], he also reported that *'he does not want to die'* and that he is overdosing *'so he can relax.'* Glenn explained that *'he did not to stop this as he likes the feeling it gives him and* ***the risk is worth it even if it was his life***. He explained that his *'main issue is anger and needing to sort it out* [I/S] *'*

17. Glenn was seen by [Dr B] (Consultant Child and Adolescent Psychiatrist) on 1st of July 2010. During this consultation Glenn revealed that he took an overdose of antihistamine in the hope to *'get high'*. In [Dr B's] [I/S] letter to Glenn's GP dated 2nd July 2010, it is noted that *'on further expolartion, the ''high'' is indeed a desperate attempt to lift his [Glenn's] low mood. He was quite agitated and hoped the overdose would allay his agitation. This is a desperate act of self-medication.*' Glenn's is diagnsoed with *'depression'* during this consultation.

18. We as a family were never entirely clear of Glenn's actual diagnosis. Glenn was assesed by [Dr C] (consultant psychatirst) on 6th August 2010, further to which she wrote a letter to Glenn's GP. The letter notes :

'Thank you for referring Glenn whom I assessed on 6th August 2010…

At interview Glen was well presented. He appeared anxious and on edge but was pleasant in manner and reactive. He spoke fluently without pressure. He described his mood as 'a bit low' rating it 3-4/10. Objectively he appeared anxious and possibly depressed. He has marked initial insomnia and variable levels of anhedonia. He describes frequent thoughts of self harm which he has been resisting in recent weeks. He has occasional suicidal ideas for example four weeks ago following an argument with his mother he had thoughts of drowning himself but denied any planning or intent. However he admitted that he can be quite impulsive. With regard to thought content he admitted that he has recurrent intrusive fears about his sleep disturbance. He told me he doesn't really care about what happens to him, only about protecting his mother. For the future he hopes that he can overcome his problems ***but is worried that he may die accidentally****. With regard to perceptual abnormalities he describes occasional feeling of unreality probably depersonalization normally when highly anxious. However he denies psychotic experiences. His cognitive function appeared intact I assessed his intelligence as being in the normal range….*

'He [Glenn] has marked initial insomnia and variable levels of anhedonia. He describes frequent thoughts of self harm which he has been resisting in recent weeks. He has occasional suicidal ideas for example four weeks ago following an argument with his mother he had

thoughts of drowning himself but denied any planning or intent. However he admitted that he can be quite impulsive. With regard to thought content he admitted that he has recurrent intrusive fears about his sleep disturbance. He told me he doesn't really care about what happens to him, only about protecting his mother. For the future he hopes that he can overcome his problems but is worried that he may die accidentally. With regard to perceptual abnormalities he describes occasional feeling of unreality probably depersonalization normally when highly anxious. However he denies psychotic experiences.'

19. My concern here is that **Dr C** does not seem to be addressing Glenn's frequent overdosing in a meaningful way. In addition, **Dr C** advised Glenn to continue taking his medication despite knowing that he had a history of overdosing. Whilst I understand that medication is one way of treatment, why is it that no consideration is given to find an alternative treatment to address the issue of overdosing?

20. A letter from Glenn's **CPN** to his GP dated 13.08.2010 states that *'...Glenn was seen by CAMHS Crisis Team for 8 weeks following his alleged overdose in June. During this it gave him the opportunity to explore his thoughts and feelings around the overdose and identify more adaptive ways to manage his feeling. Glenn continued to deny that he had any suicidal thoughts, plan or intent and his overdose was a means of relaxing. Glenn was discharged from our services on Monday 9th August and is now seeing* **Dr C** **[I/S]** *within the Adult Mental Health Services.'* My comment on this is

that any professional involved in treating vulnerable patients with mental health difficulties should know that overdosing for the purpose of '*relaxing*' is not normal. Why is it that aside from recognising that overdosing is an issue for Glenn, no actual action is taken to address this?

21. There seems to be an attitude amongst the treating clinicians that if Glenn does not appear to be 'bad enough' to be sectioned, there is nothing they can do to meaningfully intervene and help him refrain from self-harming or overdosing.

22. Further to Glenn's request for an earlier consultation, he is seen by **Dr C** on 13th September 2010. **Dr C** discussed *'possible treatment options'* with Glenn, though it was concluded that *'in practice theses are quite limited partly* ***because of his age and partly because of his history of overdosing behaviour****'*.

23. Glenn was reviewed again by **Dr C** on 13th December 2010, and he reports his '*mood as six to seven out of ten but admitted that following arguments with his mother* ***he still experiences suicidal thoughts'.*** **Dr C** notes that *'Fortunately he [Glenn] has not acted on these or self-harmed in anyway recently. He continues to express concern about ongoing issues within the family. Fortunately, he remains free from psychotic symptoms.'* Glenn is discharged with medication and a further face to face review is arranged for

14th February 2011. The only therapeutic intervention Glenn seems to be getting at this point was the counselling sessions at his school. My obvious question at this point is that isn't '*experiencing suicidal thoughts*' serious enough to warrant actual therapeutic care or at least to be deemed as high risk? **At this point I would like to reiterate that Glenn had a history of self-harm and suicidal tendencies. Therefore, why is it that Glenn continuing to experience suicidal thoughts not seen as majorly concerning?** In any event Glenn was unable to attend his follow up appointment on 14th February 2011 with **Dr C**

24. Until June 2011, Glenn appears to have had no contact with the mental health services. Glenn was seen by Dr **[I/S]** for a follow up outpatient appointment on 20th July 2011. During this consultation, it was noted that Glenn's last overdose was in April 2011, when '*he took a few sleeping tablets*.' The main complaint that Glenn presented with was '*complaints of anger*'. Glenn also reports that *'he tried to release his anger by punching the walls and at times has hit others'*. Glenn was prescribed medication for 28 days and was referred to anger management services. It is acknowledged that Glenn is at ongoing risk of suicide albeit this risk is deemed to be '*low*'.

25. On 21st December 2011, Glenn was referred to the '*mental health team by EAU following overdose* **of prescribed medication and alcohol.** ' Glenn was assessed by the community mental health nurse **[I/S]** and he reported to have '*expressed a desire to jump off the hospital roof whilst*

intoxicated' The records further note that *'Glenn was taken into A&E ...'* after he ran from home telling our mother that he was *'going to the woods to kill himself'.* Having read this entry in the records, the nurse who examined Glenn seems to have no sense of urgency or understand the significance of this incident. Glenn is advised to *'self-refer to Beacon House for anger management'* and is informed that the nurse will attempt to book Glenn for an outpatient appointment with **Dr C**. This is highly concerning for me, as Glenn's presentation in this consultation should have raised alarm bells to anyone involved in his treatment. I would have expected immediate sectioning or constant monitoring when someone is reported to have informed their mother that '*they are going to the woods to kill'* themselves.

26. According to the medical records I have, no further consultations take place until March 2012.

2012

27. On 6th March 2012, Glenn is seen at his GP practice for an emergency consultation as he had ran out of his medication. Glenn reported feeling *'low and depressed'.* Glenn's previous '*suicide attempts'* were discussed. Glenn also reports some recent '*superficial cutting'* that he regrets.

28. On 7th March 2012, Glenn was admitted to A&E due to alcohol overdose. He was drowsy and unable to recall events. Glenn was assessed by the crisis

team during his attendance at the A&E department. He is reported to have continued *'suicidal thoughts, plans and intent'.* Due to the high-risk nature of this event, Glenn was offered an in-patient admission in the mental health unit, and he accepted this. Glenn was taken to The Lakes Mental Health Unit in Colchester, on an informal basis.

29. On 9th March 2012, Glenn was reviewed during his inpatient stay where he reports that *'3 weeks prior to admission…he made a ''perfect plan'' for suicide'.* The serious incident report (SII) dated 02.08.2012 states that Glenn had left *'a suicide note'* and that he was initially compliant with the treatment but did *'self-harm intermittently'*. On one occasion Glenn is reported to have *'left the unit and tried stepping in front of a moving car'.* Glenn continued to present with *'low mood, mood instability and also passive suicide ideation'.* At one point Glenn stated that he wanted *to 'jump off a bridge in front a moving train.'* Further to this statement from Glenn, his leave from the ward was cancelled.

30. Glenn was discharged from inpatient services under **Dr C**'s care on 04/04/2012 with a prescription of Pregablin for anxiety, together with Sertraline and Clonazepam. Again, this was despite knowing that Glenn had a history of overdosing. Those treating Glenn and those involved in Glenn's treatment were aware that he was at risk of suicide. For example, in correspondence from **Dr D** dated 04.05.2012, it is noted that *'The nature of his [Glenn's] illness is such that there may be* ***relapses during which***

Glenn poses a risk to himself in terms of deliberate self harming behaviour and suicide..'.

31. On 19.06.2012, Glenn was admitted again on an informal basis for overdosing on **a large amount of** prescribed medication and for drinking bleach. The SII report states '*He [Glenn] felt that his father had possessed his body and was controlling his thoughts and actions'.* Glenn also reported that because he had an anxiety attack '*he smashed a glass, then made cuts to his arms with the glass'* and that as there was *'blood everywhere'* he called the police.

32. Despite Glenn being in a very vulnerable position, the Care Programme Approach (CPA) assessment document (referring to the admission on 19th of June 2012) states that Glenn had '*no abnormal beliefs or perceptions and appeared cognitively intact'.* This was despite Glenn reporting that his '*father had possessed his body'*. Under the Risk Management section of the CPA assessment, it is noted that there was *'no evidence of suicidal or self harming thoughts'* and that Glenn '*denied DSH and OD as a suicide attempt'.* Glenn was to be '*discharged home to be housed in supportive living in a few weeks'* time. How can it be that he was fine mentally and that he did not show any evidence of self harming thoughts when he was admitted due to serious self harm?

33. When Glenn was assessed on 20.06.2012 he also reported to being '*possessed by the spirit of his father, whom he states was diagnosed with schizophrenia'.* I would like to reiterate that as far as I am aware, this information was also not taken seriously by the treating clinicians.

34. On 22nd June 2012, Glenn was discharged into the care of the Home Treatment Team. To my understanding, the treating clinicians had decided Glenn was fine to be discharged, simply because he agreed that he no longer needed to be on the ward. How can someone who overdosed and drank bleach a few days ago, agree to anything regarding his treatment with a sound mind? In the discharge summary dated 03.07.2012 (referring to Glenn's admission on 19th June 2012) completed by **Dr D**, there is a clear reference to Glenn's concerns. It notes :

> *'. When Glenn was seen on the ward the following day he found it difficult to recollect recent events and stated that his father had possessed his body and was now controlling his thoughts and actions. He was concerned he had Schizophrenia and requesting antipsychotic medications....*
>
> *.He was reviewed on the 22nd June 2012 and he revealed he was angry towards his father* **[I/S]**.
>
> **[I/S]**
>
> *Final diagnosis plus ICD10 code*
>
> *F60.3 Emotionally Unstable Personality Disorder*
>
> *Care Plan*

Psychotropic medications:

- *Sertraline 25mg od*
- *Pregabalin 200mg tds*
- *Diazepam 5mg od*

35. On 25th June 2012, Glenn was seen by **Dr E** CT1, as an outpatient where he explained that the stress surrounding his personal life in relation to finding a suitable accomadation *'eventually led him to take the overdose'* on 19th June 2012. Glenn reported *'suffering from hearing voices of his father most of the time.. and that usually his father's voice will command him to harm himself and* ***also tells him about different ways of killing himself.'*** I would like to inform the inquiry that roughly once a week Glenn would call me and speak like our father, and then he would go back to speaking like himself almost straight away. Alcohol appeared to worsen these episodes, acting as a trigger for my brother. Even when Glenn was in a good mood, he would still have these episodes.

36. My concern is that during the appointment on 25th June 2012, Glenn is *'assured'* by **Dr E** that hearing *'the voice of his father was not a true auditory hallucination'*. **Dr E** does not appear to explain how he reached this decision. Glenn had often made clinicians aware that he heard voices of his father, and this was not the first time this was raised. If this was not auditory hallucination, what was it? Glenn's '*working diagnosis*' at the time of this consultation was *'Mild Depressive episode, Mental and*

Behaviour Disorders due to use of cannabis and alcohol'. There appears to be a lack of concern or compassion fatigue with patients who have a history of substance misuse. The clinicians seem to dismiss other symptoms and group all symptoms into mental disorders that stem from substance abuse. In addition, yet again no measures were put in place to address Glenn's main issue of overdosing.

37. On 26th June 2012, the Home Treatment Team visited Glenn at home and it was noted that *'self harm scratches on his arms were now open and red'* and that he *'admitted to have been picking at them'.* Glenn was discharged from the Home Treatment Team on 3rd July 2012 and he was back to being an outpatient.

38. On 7th July 2012, the telephone crisis support service team received a phone call from the Trust. The Trust informed the crisis team that our stepfather had contacted them and informed them that he had been unable to get in touch with Glenn and that he had requested a welfare check by the police. Upon entering my brother's residence, the police found him deceased. My brother died on 7th July 2012.

After Glenn's Death

39. The news of my brother's death shocked me. To make matters worse, I was very distressed to not have heard anything at all from the Trust. I was only contacted by the hospital because I asked for a meeting after Glenn died.

40. I did not know that I could have had legal representation at the inquest into Glenn's death. I do not believe that Glenn meant to take his life. I am of the view that his actions were a cry for help.

41. I wanted to see Glenn before the cremation. Glenn had been deceased for a while by the time I saw his body. There was a foul smell, and maggots were coming out of his eyes. It was awful.

42. As I was very disappointed with the care my brother received from the Trust, I made a complaint to the Parliamentary and Health Service Ombudsman. My complain was partly upheld, and a copy of their response can be provided should the inquiry wish to see this.

Ward environment

43. To my understanding and recollection, patients could escape from the ward quite easily. As far as I am aware, any patient who wanted to leave the ward was able to do so easily. If and when they came back they were not searched upon return. The doors were not safe enough to ensure inpatients did not leave the ward.

44. I do not know about the meals Glenn had whilst he was an inpatient. What I do know from Glenn, is that there weren't many snacks for inpatients. Glenn always took a lot of snacks with him as he was always hungry at the ward. There were no exercise facilities or nothing by way of stimulation at the ward.

45. I do not feel that the ward environment assisted with Glenn's recovery. There were times when Glenn would be sleeping on the floor in the ward without a mattress. Sometimes he and other patients would also sleep on the floor in the corridors.

Staffing Arrangements, Training and Support

46. Each time I visited, I noticed that there were no staff on the ward watching the patients. Staff were in the staff room playing solitaire with each other. I would knock on the office to get a staff member's attention and would have to wait for them to finish their game before they would speak to me. I felt completely ignored and this happened every time I visited Glenn.

47. On one occasion when I was visiting Glenn, a member of staff told me that '*Glenn is attention seeking, you need to back off, stop visiting, leave him to it and he'll get over it*'. She also said '*he's only going to do it once isn't he*' referring to him taking his life. They did not understand that my brother had a serious mental condition. He was always dismissed as being impulsive.

Recommendations and further investigations

48. Patients with a history of overdose should receive therapeutic care and clinicians should understand the actual reason as to why patients engage in overdosing.

49. Self-harm of any kind should be taken seriously. Clinicians must understand the complex nature of suicidal thoughts and recognise that there is no one treatment that will work on all patients. Mental health illnesses are complex,

requires effective research and a willingness from clinicians to try different methods of treatment.

50. I would like the inquiry to investigate whether the combination of psychotropic medication prescribed to Glenn played a part in further deteriorating his mental health. Should he have been on so much medication? Was the dosage correct and did the clinicians take appropriate care to ensure that Glenn was in fact given the right medication?

Disclosure

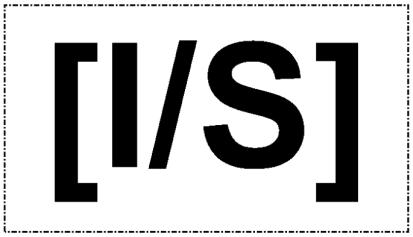
51. I do not have a full set of Glenn's medical records and I would like the inquiry to obtain both his GP and hospital records.

The Documents I Have

- Serious Incident report dated 02.08.2012
- Medical records (incomplete)
- Complaints response from the Parliamentary and Health Service Ombudsman 11th December 2015

Statement of Truth

I believe the content of this statement to be true.

Signed: 

Dated: 09.01.2026