WITNESS STATEMENT OF SIMON MARCOVITCH PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **Mr Simon Marcovitch** ([I/S] [I/S]) am the father of Daniel Lee Marcovitch (born on 7th September 1977; died on 11th January 2022.)

2. I am making this statement from a combination of own my own memory of events, knowledge, belief and having access based on my memory of events, from having seen my late son's records / other disclosure and the evidence placed before the inquest (into my son's death), which began on 07 July 2023 and concluded on 07 July 2023.

Diagnosis

Daniel's upbringing and lead up to development of mental health issues

3. Daniel as a youngster use to cry all the time. I remember, Daniel would slam doors and would seek attention. He would also kick out at his teachers. Because of his behaviour, we sent Daniel to a boarding school at aged 11 which was private, and they found him to be too aggressive and always fighting, so he only managed to stay there for one term before leaving.

4. Whilst Daniel was still young, his mum **and I separated and Daniel lived with me while his sister went with her mum.**.

5. When Daniel was approximately 11 years of age, Daniel told me that he was consuming drugs. Daniel would hang around with people that I would term 'proper gangsters. As Daniel's behaviour was becoming out of control, we got the police involved.

6. On one occasion, around the same age, I went to work, and Daniel had a key to the house. He didn't go to school, that day and he was hanging about with grown up men **(his sister** told me this at the time) who were buying and selling drugs. That evening

Daniel went missing and we called the police, it was then he was located, and we found out that he had been at a drug den.

7. It was later on in life that Daniel told me that he was selling drugs from my home. Due to selling drugs, Daniel had amassed more money than he ever could, had he gone to work. However, Daniel selling drugs from my home at this time had consequences, as within a period of 2 weeks, I had been burgled twice by men who had wanted my possession of my stereo. When I got home and found out, I said to Daniel, that when I come home from work, he could do as he wanted, but on the condition, that he went to school. Daniel didn't listen to my plea at the time, as soon after on a separate occasion, I received a phone call at work, saying that I had been burgled again.

8. You have to understand that as a baby Daniel was in Kellogg's adverts and he was so handsome, however, once he mixed with these people, he took every drug and his personality changed indefinitely. He was hanging out with these people before his mum left, and he mixed with the wrong crowd who got him into supplying and taking drugs.

9. I believe that another factor to the development of Daniel's mental health issues, was his lack of relationship with his mum. [I/S] [I/S] [I/S]. I believe the separation between myself, and Daniel's mum was always a problem for him and contributed to the development of his mental health issues.

10. Additionally, the development of Daniel's mental health was not helped by the fact that there was an occasion, when **Daniel was physically assaulted** **[I/S]**

11. Daniel [I/S] [I/S] would divide his time between his grandparent's and my home. Even after Daniel left prison and told me he wanted to see his mum, to establish some form of relationship, never allowed him to come to the house she shares with [I/S]

Interactions with the police

12. There was an occasion when Daniel was arrested, I can't recall what for. However, I do remember that he went to Limehouse police station because we lived there. As Daniel was 16 at the time and therefore, underage he had a care person to represent him. When at the police station I remember that they said to Daniel that he would get to an age where they would not call his parents, and he would have to deal with the consequences of his actions himself.

13. Daniel did not heed this warning and eventually went to prison at age 16 for possession of drugs.

14. As far as I am aware, Daniel did not get a mental health diagnosis until he was out of prison. He entered the prison system at aged 16, when he was remanded at Feltham young offenders. From there until his final release from prison, Daniel was in and out of prison, which went on to become a lifetime thing. I would visit Daniel as often as I could whilst he was in prison, even when they would move him around the country to different prison, from time to time.

15. After Daniel's release from prison, I began to notice issues with his mental. I also later found out, after reading his medical records, that he had attempted to take his life twice, whilst in prison.

Daniel's first contact with mental health services

16. When Daniel came out of prison, for the final time he had completely changed in his behaviour, as he had stopped consuming recreational drugs. The reason for him stopping this, was due to covid, as prisoners weren't allowed any visits so everyone in prison went cold turkey, as there were no drugs available for them.

17. He also told me that whilst he was in prison, he was not given a mental health diagnosis. But that he was prescribed mental health medication.

18. Upon leaving prison, Daniel did not understand anything about anything, as he had been inside prison for so long, that he was institutionalised. Therefore, immediately after his final release from prison, I had to help him through this period. Initially, Daniel moved back to Chelmsford with me, in an over 60s home I was living in, which was fantastic, as I felt that I had my actual son back, for the first time in a long time.

19. There is a letter from Daniel to where he expresses the issues he faced after living prison *"due to being institutionalised for 24 years in prison"* where "*the meals were already prepared".*

Preparing food

20. Daniel in this letter goes on to state *that "…throughout…child and young adulthood"* that he had *"…not really gained any life skills with preparing and cooking meals"* and had also *"…always struggled with…mental health ever since"* he *"…was young, so…would go days with out eating or drinking"* and *"…would then rely on drug use which over the years"* had *"…given…lots of anxiety and depression."* Daniel goes on to state that he *"…struggles with concentrating and taking information in…even though…can read, trying to read a receipt and trying to understand this…would have to re-read so many times, that"* he *"…then become even more anxious and then"* would *"…get angry…as…feel…cannot do anything."*

21. Daniel also stated that he had a very good relationship with me now, as I was *"…helping and prompting"* him, but that he had *"…very dark and low moods daily and when…like this…will not attempt to prepare anything."* Furthermore, Daniel noted that he suffered with severe pain in his back as he had *"…two damaged discs"* in his back which affected his *"…mental health and causes even more anxiety…".*

22. Daniel continued stating that he suffered from *"…severe memory loss"* so that his *"…biggest anxiety is if"* he *"…was able to prepare and cook anything"* he *"…would forget that I had this in the oven or any other cooking equipment"* which *"…could then cause some serious damage and be a major risk factor."*

Eating and drinking

23. Daniel also mentions that suffering from *"…severe mental health…causes…to have very dark days…"* and when he is *"…like this, the last thing…"* he wants *"…to do is eat or drink…".* He continued stating that *"…whilst in prison, food was prepared and even then…could go days without eating or drinking…"* As he suffered from *"…severe anxiety and depression"* he would *"…always worry about what I am eating. Over the years due to…drug usage, this again stopped"* him *"…from wanting to eat or drink…"* but that his *"…body has got used to this and adapted to this way of life…"* He also noted that as he suffered from *"…severe memory loss…can forget to eat"* and gets *"…prompted from my father at times."*

Managing your treatments

24. Daniel further states in this letter about his mental health, that *"due to being institutionalised for many years I have not had to deal a lot with managing any treatments as this was all dealt in house whilst I was in prison.*

25. *Any medication or therapy I had to take and attend was all mapped and arranged for me. I would then be encouraged and prompted to attend.*

26. *Since being released and being put into my own accommodation, I am finding it really hard to cope and understand all aspects of treatments and managing a tenancy.*

27. *My father has been a big support to me, and without this, I would not know where to begin. I do not understand how services and agencies work so have been struggling with this. This can make me become very easily frustrated and agitated.*

28. *Due to my memory loss and with issues with drug use in the past, I am now engaging with a drug agency who have been supporting me. I am now able to collect my methadone weekly. I have relied on this since around the age of 17 years old, and also take this for my pain relief which was given to me in Prison. When it comes to other treatment, my father has been the person that has set up appointments with other agencies, even registering me with a doctor and attending appointments with me.*

29. *He has supported me with dealing with the housing, outreach agencies and also benefits. I find it very hard to be able to express how I am feeling or how I am coping.*

30. *I find it very overwhelming to deal with all this.*

31. *My father has also supported me with now being able to get my medication weekly rather than monthly. I have accidently overdosed a number of times in the past and even since being released from prison in July 21."*

Washing and Bathing

32. In relation to washing and bathing, Daniel states that *"…I struggle with this task. I struggle with my mental health and have very dark and deep thoughts. I have struggled for many years with looking at my body. Possibly body dysmorphia - even though this*

has not been diagnosed. I have many scars from self-harming and other incidents which has caused me not to like what I see when I look in the mirror.

33. *When I feel like this, I can stay in bed for days on end and will not have a wash or shower.*

34. *Also, due to the pain that I suffer I find it hard to stand for a while so this also stops me.*

35. *I often feel that I have nothing to have a wash or bath for. I have very low self esteem and my confidence is very low.*

36. *Using the toilet and managing incontinence…"*

Using the toilet and managing incontinence

37. Daniel commented also about his incontinence issues affecting his mental health, stating *"…I suffer from incontinence and leakage from the bowel. I also bleed from my bowel. This is being investigated. This causes my anxiety to flare up which then results with my mental health declining. I cannot stand for long without wetting myself. Because of this, I tend to also not want to leave my property and feel that people will judge me"*

Dressing and undressing

38. Daniel wrote about dressing and undress, that *"…even though I can dress and undress myself, I do struggle with wanting to get up and get dressed. My father has to prompt and encourage me m especially if I have to attend an appointment.*

39. *Also I struggle for standing up to long as the pain that I suffer in my back can make me feel very ill and unsteady."*

Talking, listening and understanding

40. Daniel mentioned that another aspect that affected his mental health was talking, listening and understanding in general, explaining that *"…this is something that I am really struggling and getting very anxious about.*

41. *I have not had to deal with the outside world for many years since early adulthood. Things seem very strange and I am unsure of how to speak to people or act.*

42. *I get easily agitated and very frustrated. I struggle with taking in any information and always feel that people will judge or laugh at me. Over the years, I have had to keep all my emotions inside as I have been told I am overreacting. I feel that at times I am trapped with my thoughts and because of this, struggle to talk about things.*

43. *I feel that people do not understand me.*

44. *My father has been supporting me to work and deal with all outside agencies. I now have got a Support Officer who has been helping me, but due to lack of understanding how things work, she liaises a lot with my father.*

45. *I do not have a lot of trust with people so I try to avoid situations."*

Reading

46. Daniel also confirmed that reading impacted his mental health explaining that *"…I can read, but I do struggle with taking in any information. I suffer from memory loss and even if I re-read over and over again, things do not register with me.*

47. *I do feel I need on going support to help me work on this.*

48. *Mixing with other people*

49. *For the past 24 years I have not had to deal with people outside of prison.*

50. *I have adapted to the people whom I have been with.*

51. *Now I have my own tenancy, I am struggling with meeting people whom I do not know. If get very anxious and this causes my mental health to * really decline. I feel that people are laughing or judging me about my past.*

52. *I am also not used to how people can act or behave to others.*

53. *I have only just started to build up a repour [rapport] with my father and also*

54. *I am also not used to how people can act or behave to others.*

55. *I have only just started to build up a repour with my father and also working with some agencies."*

Managing money

56. Daniel finally in the letter commented on his ability to manage money, which was also impacting his mental health, stating *"…My father supported me with setting up my benefit claim and talking to the benefits team. I have not really had to deal with money so find it hard to understand what to pay and what needs to be set up. I am now giving my father my benefit money and he supports me with paying my utilities and then making sure I have some money to help me get through. This is a big support need that I do need support with has I have not had to budget before. I have not had a tenancy in a long time."*

Open Road

57. Once Daniel was realised from prison (HMP Stocken) on approximately 04 June 2021, Daniel and I sought and received help from several agencies including, Open Road, to manage his drug addiction. Daniel would collect methadone weekly, which he had also been using whilst in prison, as a substitute for the drugs he had been taking.

Chess housing charity

58. As I was living in an over 60s home, one of the conditions of my stay, was that no one else could occupy the room with me. Therefore, whilst initially Daniel was able to live with me, we had to find him suitable accommodation. Therefore, Daniel and I approached Chess housing charity, who were amazing and managed to find Daniel suitable accommodation.

General practitioner

59. In order for Daniel to receive help for his mental health issues and be accepted at the Linden Centre, he couldn't just go to them directly and explain he was seeking help. Daniel was told that he would need to be registered to a GP, for assessment for his

mental health and thereafter, if it was found that his mental health was deteriorating, they would signpost him for treatment. Therefore, on 09 June 2021, Daniel registered with GP, Beauchamp House Surgery.

60. Having considered Daniel's GP records, at page 24, it details on the day of him registering with the GP surgery, the following:

"History: tele triage
Recently released from prison
Asking for meds – has brought some meds with him Quetiapine 200 mg tab and pregabalin 225 mg, unsure if these meds are in date and also reg schedule of meds- pt awaiting in reception for meds

hx from pt and then from dad, released from prison on Friday, been in prison for 6 yrs and 2 months, asper pt- was compliant with meds and taking all meds reg-
seeking pregabalin 225 mg BD and Quetiapine 200 mg BD
there is no letter from jail, explained I would need proof of what medications he was being given in HMP

as per dad, open road have contacted HMP for medications (as needs Methadone as well) – so dad can bring this from open road tomorrow.
Plan: will acute meds for 7 days, await letter from HMP to review meds
Pregabalin 225mg capsules – 14 capsule – take one twice daily
Quetiapine 200mg tablets – 14 tablet – 1 twice daily…"

61. On 15 June 2021, according to Daniel's GP records at page 25, it states the following:

"…Came out of prison 1.5 weeks ago, was in there for 6 years. Lots of diagnoses whilst in prison.
…diagnosed with EUPD. Awaiting apt with psychiatrist, says can't work due to back pain and MH…
…Diagnosis:….emotionally unstable personality disorder, post traumatic stress disorder…"

62. On 17 August 2021, according to Daniel's GP records at page 28, it states the following:

"…mental health issues- taking 200 mg twice daily (Quetiapine), needs it to be increased-

has sick note- given for a month- asking for at least 3 monthly sick notes as has 'long term health issues' that would not sort out in a month-

…takes Pregabalin, explained- this also helps with MH issues- note dose was recently inc-

Also note episode of OD

Plan: reg MH issues, explained- would need to be referred to MH service- for inc Quetiapine…"

Daniel's first contact with EPUT on 18 August 2021

63. Having considered Daniel's medical records, it appears he may have first came into contact with Essex Partnership University Trust (EPUT) mental health services, on 18 August 2021, as it is documented that he was referred to EPUT by his GP, Beauchamp Surgery.

64. It is noted at page 25 of the EPUT records that, there was an *"…Urgent duty triage"* by Healthcare professional (HCP) nurse, **[I/S]** as *"GP referral requesting review due to concerns for recent overdose on medication.*

diagnosed with EUPD, PTSD and opioid dependency. Prescribed Quetiapine 200mgs BD, Pregabalin 200mgs TDS and Omeprazole.

Daniel was aware of referral and happy to speak to me.

He reported feeling:

Anxious

Tearful all the time

Needing his dad to go out with him

Scared by the outside world

He has no friendship groups or girlfriends.

When discussing risks he advised that he has tried to hang himself twice, many years ago, and has cut himself with razors.

Once time was with a view to suicide, whereas the other times he stated were 'cries for help'. He did not wish to discuss the excess medication overdose, but stated that he is not wanting to try and kill himself.

Daniel is prescribed Methadone 80mls by Essex Stars.

He has accessed psychiatry in hospital, but not in the community. Daniel does have a support worker, **[I/S]** *at Peabody.*

Plan:

Daniel to be offered a routine B6 appointment in order to conduct a full assessment of needs, history and risks."

65. I must confess that I do not recall Daniel having overdosed at this point in time, as to my recollection, he was already under the care of EPUT and the Linden Centre, when he overdosed at Broomfield hospital, as I remember Broomfield writing a letter to the Linden Centre explain that a patient of theirs (Daniel) had overdosed.

66. On 24 August 2021, I recall attending the Linden Centre in person, along with Daniel, as I couldn't get through to EPUT on their telephone line, to arrange a mental health assessment for Daniel. Whilst there, I asked whether Daniel was under the care of his GP for his mental health care or the Linden Centre and I was told, Daniel was under the care of the Linden Centre.

67. On 12 October 2021, I believe Daniel was interviewed/ assessed, by EPUT and they said to us both that Daniel has a lot of mental health issues, and that he was in danger of overdosing. As a result, we were told that Daniel would now be under EPUT and the Linden Centre's care and they would make him better. We were also told that EPUT were the only ones who could change his medication, and that he would be given a case worker. That is how it started. I was smiling so much when they said that because I thought he was going to get help for his mental health, for the first time ever.

Daniel's diagnosis

68. Whilst Daniel was in prison, he was diagnosed with Emotional Unstable Personality Disorder (EUPD), but I wasn't aware of this until he was released from prison in June 2021. When Daniel was assessed on 12 October 2021 by **HCA Nurse** at the Linden Centre, this was the first time I had heard any mental health diagnosis relating to Daniel, as I remember her discussing Daniel's EPUD diagnosis that had taken place whilst he was in prison.

Assessments

Daniel's assessment at the Linden Centre on 12 October 2021

69. On 12 October 2021, as I have briefly touched upon above in my statement, Daniel was assessed in the Linden Centre by **HCA Nurse**, where it was noted that he 'could be a risk of overdosing'. As I have stated in my commemorative account, on this occasion, he was not admitted as an inpatient, despite this real risk of harm to himself.

70. Here is an excerpt of Daniel's assessment on 12 October 2021, on page 24 of the EPUT records, that should ring alarm bells.

"…Daniel reports that for a long time he thought he was a "mad man"…says that he goes through a range of emotions one day feeling ok, the next feeling angry…and can react impulsively in an aggressive manner.
…Daniel admits to having addiction problems. He started to use heroin and crack as a young teenager and developed addictions over time to Valium and other medications…
…RISK/PLAN:
Daniel clearly needs some input with his mental health management. He is diagnosed with EUPD and said he didn't really understand his diagnosis properly or how to manage it apart from taking medication.
He has been over medicating on his meds…pregabalin…but could be a risk of overdosing.
…to have some BI [brief intervention] to establish coping skills and assess whether suitable for pathway for longer term management…"

71. I do not understand that despite EPUT acknowledging that Daniel could be at risk of overdosing, including the history he had provided during his first assessment on 18 August 2021, why he wasn't either assessed under the mental health act (MHA) for the purpose of sectioning and/or admitted as an informal patient. It is baffling that as a vulnerable individual, you go to a mental health facility, where they have confirmed that you're under their duty of care and acknowledge that you're at risk of overdosing, yet they decide not to admit you as an inpatient either formally and/or informally.

72. In addition to the above, surely, they should have had access to Daniel's medical records, from his time in prison, which would have given an even clearer insight into the history behind his mental health, including his previous attempts to kill himself, that should have led to him being an inpatient at that time.

73. I genuinely thought at the assessment of 12 October 2021, that everything was in the Linden Centre's hands. Surely, if someone refers you, then you must have information to hand, as to why that person has been referred, e.g. information where it clearly states that Daniel was at risk of overdose.

Daniel's final days and missed call from EPUT

74. Daniel started to blow up and get bloated. I had asked him if he was taking more drugs than he was prescribed by his doctors and he said *'yes'*. He was buying more prescribed drugs on the black market. The biggest problem for those who are addicted to drugs and/or have drug problems is that doctors are prescribing opioids and then those individuals use the prescribed drugs they receive as a currency/money by selling it on the black market and use the money for their habits. For example, if you were to go to the boots in Chelmsford, there is a row of people queuing up for methadone, which are all opioids.

75. Daniel didn't get a missed call from EPUT, because that Friday, I was in the car with him. The aspect of my commemorative account where I explain that just before Daniel died, his mental health was being evaluated by doctors, but that on the Friday he missed a call from them and by the Monday he had died, is incorrect. What actually transpired was on the Friday me and Daniel were driving and the Linden Centre phoned him, and he put the call on loudspeaker.

76. The clinician on the call, who was a male, explained he called Daniel, as he was told to see how Daniel was keeping (to my mind this was an assessment). As the call was on loudspeaker, I said that I had kept on ringing the Linden Centre because Daniel's appearance was concerning me, as he was bloating and not doing well mentally. The clinician then put the phone down on me. Within 30 seconds, the lady in charge of the Linden Centre, who I understand to be **A** called me and apologised. At the time, I was going mental and she calmed me down, as I simply wanted continuity of care for Daniel because so many different people were calling him, and merely doing basic check-ups on him, *"how are you doing", "how are you feeling", "how was your*

day" as opposed to a proper assessment of his mental health, that was clearly deteriorating. During the call, I explained to **A** that Daniel was bloating and I was worried about his prescription. **A** told me during this call, that she would sort something out by Monday in relation to getting Daniel help, for his clear and visible mental health deterioration and then he died on the following Tuesday. My expectation was that **A** was and should have said that Daniel was being admitted to the Linden Centre.

77. On the outside everyone at this stage could see that Daniel had mental health problems. For example, his mental health had deteriorated to such an extent that the job centre wouldn't even ring him up about finding work, they just paid his benefits. In addition, Open Road recommended him to chess charity, as they could see he had severe issues and required rehousing.

78. Chelmsford council could also see that Daniel had serious mental health issues, and every Friday would notify him that he could bid for a property.

79. Daniel was under the care of the Linden Centre and instead of ensuring he had adequate mental health assistance, they left him alone. All they kept saying is that if he was in danger, he should contact the crisis line. I am sure there will be a recording somewhere of me going mental on the Friday over the phone. Then that following Monday, I had to go to London for an endoscopy and then on Tuesday, I found my son, Daniel dead. They were not sure if Daniel had died in the early evening or the early hours of Tuesday morning.

80. It is my strong view, that when **A** called me back, that she should have brought Daniel in for an immediate assessment, given his presentation and what she had been told about his mental state and not wait until the Monday. Because I was extremely worried about Daniel because he was knowingly taking more drugs than he should've been taking and he was swelling up.

81. Additionally, when the male clinician rang Daniel, I would have expected for example for him to say where he is from e.g. *"Hi, I am* **[I/S]** *from the Linden Centre, and I am a caseworker here to assess your son and his mental health".* Frankly speaking, had my son not gone to the Linden Centre and let his guard down, thinking he would get the appropriate mental health help, he would still be alive.

Missed mental health assessments

82. Yes, there were several instances when I believe there were missed opportunities for mental health assessments for Daniel. For example every time he was called after EPUT caseworker 'CW' who was assigned to Daniel for the brief intervention went on annual leave and other caseworkers called Daniel to check up in his place and merely asked him *"how are you doing"* rather than conducting proper assessments, by assessing and gauging in detail how Daniel's mental health was by asking him probing and meaningful questions and doing what their role required of them.

83. A specific occasion that reflects this, is recorded in Daniel's EPUT medical records at page 19, whereby a support call was made to Daniel on 21 December 2021.

"…Support call – Due to **CW** *being off with Covid-19:*

Explained to Daniel that **CW** *will be off for another 2 weeks, reported that he had not meet him yet and this was ok and understands. Explored how Daniel is managing from his assessment and last contact with us, Daniel reported that he is "ok" "bit of a rubbish" time of the year – explored why – stated that he was spending xmas on his own*

Reported that he has his father in Basildon – explored about making contact with him and trying to see him on the xmas week – reported that he would think about this.

Stated that he feels able to keep himself safe and was then going out – reported that he would call for support if need. Agreed to offer a support call next week.

Risk:

No new risks expressed, no thoughts to harm self-reported. Showed evidence of future planning.

Plan:

Duty to make contact on Thursday 30/12/2021 – support call

Daniel to use trust line number for support,

Made aware of NHS 111 op2…."

84. When a caseworker would call Daniel, he would apologise to them every time. There was even an occasion when they called him that he explained that he had been taking crack cocaine which I wasn't aware of and they still didn't understand that he needed immediate help. EPUT's approach is so robotic. Contact and ask basic none probing questions and say contact has been made, without delving into finding out whether Daniel's mental health was on the decline, which it clearly was.

85. After Daniel died the after-action review completed at some time in 2022, it was documented that it would've been better for Daniel to have a consistent caseworker to speak to.

86. There were also occasions where I personally contacted EPUT and the people at the Linden Centre and every time I told them he needs to be assessed.

87. From my perspective, once Daniel got into the hands of the Linden Centre , I consider each call that Daniel received from a caseworker, whether it was his caseworker Mr **CW** for the brief intervention, or caseworkers who stood in his place and provided support calls to Daniel when he was on annual leave and off sick with Covid-19, each of those to me and my mind, was an assessment. I strongly feel that all of these occasions were assessments because they were calling Daniel and asking how he was feeling. Therefore, they should have done more to ascertain what he was going through to ensure he was admitted as an inpatient.

88. EPUT and the Linden Centre didn't further investigate when Daniel was saying he was feeling suicidal. To me, it felt like those at the Linden Centre were all AI operated. Everyone just kept saying the same thing, he was given a support call. It was only after Daniel had died that they acknowledged that there should've been one person / caseworker looking after him. I feel strongly that every person who was calling him in the period that **CW** was absent for the brief intervention should have been assessing Daniel and not just basic support calls, which did not illicit any real information concerning Daniel's worsening mental health condition.

89. All my friends supported me when Daniel died. I would visit Daniel when he was in prison, and my son was my everything to me. The Linden Centre really let my son down because he let his guard down thinking he would get real support, treatment and care for his mental health.

90. What are EPUT and the Linden Centre doing after their support phone call to Daniel? Of course, their calls to him were assessments. If you have a child no matter how old, and they do a programme for him to try and make him better, when they call and he says he's feeling low, they must then write this down somewhere and take actionable steps.

My observations and concerns regarding the process and outcome of assessments

91. EPUT and the Linden Centre assessments were inadequate. The caseworkers and others just pass the buck and did not write down what adequately what Daniel would tell them about how he was feeling. All in all, if EPUT's assessments of Daniel were better and/or acted upon, he would have been admitted as an inpatient and provided with proper care and treatment, which would have seen him still alive today.

Admission

Occasions when Daniel, asked a healthcare professional to admit him or to consider doing so and he was not admitted?

92. There was such an occasion, when I believe that Daniel had asked EPUT to consider admitting him as an inpatient. This was on 11 December 2021 when as noted in the letter I received from Patient Safety Incident Management dated 16 February 2023, that he was *"…contacted by another clinician from AAT…He was asked what was going to happen during Brief Intervention and the clinician advised that some work would need to be done to support Daniel adjusting to life in society as he had been in Prison for such a long time. During the call, Daniel said that he had used crack since leaving Prison but Open Road were aware of this. Open Road had warned Daniel against using heroin due to the potential for quick relapse. Daniel said that he does not want to go back to prison, but added he was not lonely in Prison but was where he was living. Daniel thanked the clinician for calling and asked if he could have another call if the Lead Practitioner was going on leave for long and this was agreed…".* To me Daniel admitting he had taken crack, but that he did not want to go back to Prison, but didn't want to stay where he was living, was a cry for help and him essentially asking to be

admitting as an inpatient in so many words. This was an opportunity missed by EPUT to admit him.

My observations regarding decision not to admit Daniel under section

93. On 03 August 2021, Daniel was admitted to Broomfield hospital after taking an overdose. Daniel was found collapsed on the floor by a passenger by unconscious. I understand that Broomfield hospital contacted the Linden Centre regarding Daniel's overdose. Therefore, this should have triggered a mental health assessment for Daniel, which should have seen him sectioned under the mental health act for his own safety.

Treatment

Medication

94. On 20 June 2017, according to Daniel's GP records, he was diagnosed with Emotionally Unstable Personality Disorder (EUPD) and Post-Traumatic Stress Disorder (PTSD). As Daniel would have been in prison at this time, I am unsure what treatments he was offered, where it was to take place, whether he underwent any specific treatment(s) and over what period. However, given that upon release from prison, when Daniel attended his GP on 09 June 2021, he was asking for repeat medication and had brought some medication with him (Quetiapine and Pregabalin), I presume this is one of the treatments he was given to manage his EUPD and PTSD.

95. On 14 June 2021, again according to Daniel's GP records, he is noted as being diagnosed with EUPD and PTSD and he was treated with Pregabalin 225mg and Quetiapine 200mg capsules. Having further considered his records, I can see that he his prescription appears to have been issued on a repeat monthly basis. However, as Daniel was taking the medication not as prescribed, he would run out more quickly and would be prescribed interim prescriptions to cover him until the next due date.

Brief Intervention

96. Daniel following his overdose on 03 June 2021, was assessed by EPUT's **HCA Nurse on** 12 October 2021, at the Linden Centre where the plan was for Daniel to receive brief intervention (BI) treatment in the community to help him *"…establish coping skills and assess whether suitable for pathway for longer term management…"*.

97. On 18 October 202, Daniel was added to the BI waiting list.

98. On 27 October 2021, I contacted EPUT for an update regarding when Daniel was to receive his BI treatment and I was advised [I/S], that Daniel was placed on a waiting list for BI.

99. On 05 November 2021, Daniel's brief intervention was allocated to a CW [I/S] also known as CW as Lead Practitioner. In Daniel's EPUT records, its noted at page 23 that an *"…email sent to* CW *to make contact in due course."*

100. On 07 November 2021, Lead Practitioner, CW attempted to call Daniel for the start of his BI treatment, however, Daniel's mobile number was not in service. However, instead of CW alternatively contacting me, as Daniel's next of kin and due to the fact EPUT knew that Daniel had given them permission to contact me, should they not be able to reach him; CW did not do that. Instead, on 08 November 2021, CW emailed Daniel's GP Beauchamp requesting an alternative contact number for Daniel and contact details of his next of kin.

101. On 10 November 2021, a letter was sent to Daniel from EPUT advising him that they had not been able to contact him ad asking him to contact the team if he still wanted support and he was given 7 days to reply to this. Why would you send such a letter to a person who is experiencing mental health issues, advising that you're essentially closing their file if they do not contact you. A person, with mental health issues should not have the responsibility of having to make contact, especially if they're experiencing deterioration in their mental health and all steps should be exhausted, to ensure that get the support they need; in this case the BI treatment. Additionally, as I have explained above, EPUT had my contact details, as I had provided it to them, contact should have been made with me to ascertain how they could contact Daniel. Placing the onus on the vulnerable patient, is not right!

102. On 15 November 2021, I called the Linden Centre, as Daniel and I had not heard anything regarding his BI treatment. During the call, I was informed that the Lead Practitioner, CW had been trying to contact Daniel but with no success. I explained that the service to Daniel's phone had returned, as he was now paying for the phone and therefore, he should be contactable. I was then told that CW would contact Daniel again, but explained this call should be made after 11am, as the medication he

was taking was making him sleepy, and therefore, I did not want him to miss any calls from EPUT.

103. On 18 November 2021, CW made a brief intervention call to Daniel. During the call Daniel explained to CW that he tended to struggle with anxiety and going outside; and he felt that his many years in prison had affected him in many ways. It was also explained to Daniel by CW the purpose of the brief intervention work.

104. Additionally, during the call CW informed Daniel that he would be going on annual leave but did not say the duration of the annual leave, stating that Daniel would be contacted from time to time by other colleagues to see how he was doing. Daniel allegedly, did not express any thoughts of suicide or self-harm.

105. On 11 December 2021, Daniel was contacted by another clinician from EPUT, [I/S]. On this occasion Daniel was surprised to receive the call, as the number was withheld. Daniel explained to the clinician, [I/S] that he had been getting worried, as he had no follow up since he was assessed. Daniel then asked what was going to happen during the brief intervention and the clinician advised that some work would need to be done to support him adjusting to life in society, as he had been in prison for such a long time. Furthermore, during the call, Daniel told the clinician that he had used crack since leaving prison and that Open Road were aware of this.

106. Daniel went on to explain that Open Road had warned him against using heroin due to the potential for him to quickly relapse. He also explained that he did not want to go back to prison, but added that he was not lonely in prison, but was in fact lonely in where he was living.

107. On 21 December 2021, a different clinician from EPUT (as CW was still absent) called, ANP contacted Daniel. The clinician explained to Daniel that the Lead Practitioner would be off for another two weeks. The clinician explored with Daniel how he was managing and Daniel reported that he was ok but that it was a “bit of a rubbish” time of the year as he was spending Christmas on his own. Daniel also explained that he had support from me, with the clinician encouraging him to see me over the Christmas period.

108. Daniel allegedly explained to the clinician that he felt able to keep himself safe and agreed to a further support call the following week. It was also recorded that Daniel presented with no new risks had not shown any evidence of future planning and he

was told that there was a plan for him to receive another support call on 30 December 2021. Daniel was also reminded of the mental health crisis numbers.

109. On 30 December 2021, EPUT made a support call to Daniel but there was no answer, so they left him a voicemail.

110. On 31 December 2021, a different clinician, [I/S], called made a support call to Daniel, pending the return of Daniel's Lead Practitioner for his Brief Intervention, CW The clinician noted that Daniel had told them that he was still low and anxious and avoiding going out. The clinician also spoke to me, at Daniel's request and I expressed my huge disappointment about the continued delay in Daniel's brief intervention starting and just as importantly, that Daniel had been receiving calls from different EPUT clinicians, which I felt was not beneficial to Daniel and that he would benefit from having a consistent person contacting him, in CW's absence.

111. The clinician told me that they would raise my concerns with Clinical Manager, A. The clinician then discussed with A who I understand asked him to convey to Daniel and I that it the Lead Practitioner was not back at work the following week, then a different Lead Practitioner would be allocated to Daniel.

112. On 05 January 2022, Daniel had his first brief intervention session, with CW, which was a virtual appointment rather than a face to face one. I am not sure why this session was virtual as opposed to face to face and I do not believe a reason for it being virtual was provided.

113. In Daniel's case notes, following the call, it details the background and situation to his brief intervention, i.e. the GP referred Daniel for review due to concerns following a recent overdose on medication.

114. The assessment of Daniel by CW, which to reiterate was virtual is detailed as follows, on page 17 of Daniel's EPUT records, and reads:

115. *"…contacted Daniel for brief intervention. I indicated my ill health to him leading to not able to contact him as planned. He sympathised with me [and] wished me well. In respect of how he has been, he advised that he…is not crazy but has been on mental health medication for about 8 years having been seen by a psychiatrist. He advised that he has been on Quetiapine for about 8 years and would not say it helps or not but he has got addicted to them. 'if I don't have them I get chills, I get withdrawal symptoms from them, it's like being on heroine'.*

116. *He reports diagnosed with EUPD about a year ago and does not know [if] the person who diagnosed him is a psychiatrist…and was just asked to see mental health. He advised that he has…put on a lot [of] weight.*

117. *He indicates that his dad is the only person that has got his life now, ' he brings me food, I don't go out I'm always indoors'. He reports that he has no confidence, 'I lack confidence big time'. He again mentions that he had his back teeth, '4 at the top and 4 at the bottom of both' taken out affecting his confidence. He stated that he gets anxious and feels miserable most of the time. He shares that he has not been with ' a girl for 12 years, no one'. He said that he feels like people are looking at him when he is walking around, 'I don't feel like a normal person'.*

118. *Daniel acknowledges that psychological input would be helpful due to past difficulties and happy to engage with this once things have normalise.*

119. *Medication: Reports that he has previously been on Olanzapine, Risperidone, and Mirtazapine and currently on Quetiapine-200mg, ' which is the best one for me'.*

120. *He states that when he does not get this he get very anxious, horrible migraine and sweats profusely. He reported that his long term goal is to wean himself off medication. He reports that he does not want any more medication.*

121. *Physical health: Daniel describes ongoing physical health problems, ' my physical health is terrible". He advised losing blood when he goes to the toilet and has bowel problem and waiting for an appointment. He stated that a couple of days ago Broomfield hospital phone his GP to relay results of scan he had to them. He reports having two slip disc on the back of his leg and waiting for an appointment for that too.*

122. *Benefit: Reports that he has a support worker at Peabody and helped with his ' ESA upgrade' - He is currently in receipt of universal credit and trying to get PIP.*

123. *Risk: Suicidal thoughts: Reports that he tried to hang himself about 10 years ago and landed on the floor,' the bracket of the ceiling came off and I landed on the floor, I'm glad it didn't' work. He indicates, 'I'm alright in that regard, no.*

124. *Self-harm: Denies current self-harming ideations. Reports that he last self-harmed a year ago.*

125. *Psychotic symptoms: Denies experiencing any psychotic symptoms."*

126. On 06 January 2022, Lead Practitioner, CW attempted to contact Daniel to arrange his next Brief Intervention session and they agreed that his next appointment would be on 17 January 2022. This session would have arrived 12 days after his previous session.

127. Daniel did not make this Brief Intervention sessions, as he died on 11 January 2022, which was 6 days after his final Brief Intervention session.

128. Despite Daniel agreeing to attend a further Brief Intervention session on 17 January 2022, I do not understand why would EPUT arrange a Brief Intervention 12 days in the future, given Daniel's mental health struggles. I honestly believe that a Brief Intervention should have been arranged much sooner than was agreed and had the same been in place, Daniel would still be alive today. Leaving such gaps for Brief Intervention sessions, when people are clearly struggling with their mental health, is not conducive to assisting to recovery.

129. I want it to be known that when Daniel from being released from being in prison 6 months completely changed as a person and his mental health had deteriorated badly, this is why I was very angry with A. I went back time and time again to Daniel's GP and I kept saying we aren't getting any help from EPUT and the Linden Centre but I would be told that his GPs were not in control of his prescription medication. Daneil's doctor should've seen that he was agitated. He was moodier, his body was swelling up, but yet his doctor said that they can't change his prescription and that it was the Linden Centre's responsibility to make this change.

130. In relation to the dosage of his mental health medication, Daniel and I went to his GP every Friday saying that the drugs weren't working. Additionally, the Linden Centre should've assessed him a lot better than they did, and they should've been asking Daniel how he was coping with the dosage of the medication he was taking and how it was impacting his mental health, but they did not do this.

<u>My observations with Daniel's treatment</u>

131. My issues lie solely with how the Linden Centre didn't deal with treating Daniel's mental health and the lack of care for his wellbeing. The Linden Centre had a duty of care to Daniel, but from the very outset, it was clear that they failed in their duty of care to him. From the poor and pointless support calls, which should have been

assessments, when CW was on annual leave and sickness leave; not assessing the dosage of the medication to understand the efficacy and impact on Daniel's mental health (he was getting worse on the medication, because I saw him bloating up and physically and mentally changing) / be willing to prescribe different medication; the delay in Daniel having his brief intervention; and the length of time between agreed between his brief intervention on 05 November and his next arranged session.

132. In addition, had the Linden Centre had they done proper assessments of Daniel to ensure he was not vulnerable and appreciated that his mental health was deteriorating, would and should have understood that a Brief Intervention was not sufficient. This should then have led to Daniel being admitted as an inpatient, whether informally or formally (under the mental health act). But instead, they treated Daniel's mental health as something that was not of importance and that could be dealt with in the future. I am devastated, as I was the only support Daniel had, and it was hard for me. I was doing everything I could to get him the help he desperately needed.

133. I do not feel that the mental health treatment actually provided to Daniel was either adequate or appropriate. Daniel was under an organisation (EPUT, Linden Centre) which provides a mental health service which we pay for as taxpayers, and it was their duty of care whenever they would contact him for support calls and/or Brief Intervention session to assess him and make sure he wasn't vulnerable. But they did not do this for my Daniel.

134. Other concerns I have about decisions that were made about how medication prescribed to Daniel was managed, was that it centred around the management and was not monitored well enough. Had EPUT, and the clinicians at the Linden Centre spoke to Daniel properly and assessed him, as they should've realised the detrimental effect it had on him.

135. The Linden Centre had my telephone number, so they should have called me whenever they said they could not contact Daniel. A acknowledged as much, that I could and should have been contacted, when Daniel could not be reached. Had they contacted me, I would have been able to explain that Daniel required an urgent face to face assessment, so they could see the physical deterioration / decline in Daniel's mental health, which was gradually getting worse by day, due to the medication that he was taking, which was a large contributing factor. I

just wish they would've said why my son died, but in my head, he died because of the lack of duty of care from the Linden Centre.

136. Since Daniel's death, I've put on a lot of weight because of my crones operation.

Engagement

137. From my recollection Daniel was not involved and/or informed about decision relating to his care and treatment. Therefore, I do not consider that his level of involvement regarding to decisions relating to his care was appropriate. In my view, he should have had formal mental health assessments to ascertain his current mental state, as opposed to the pointless support calls and to an extent the brief intervention sessions he had.

138. All Daniel would get were phone calls from various different AAT's just asking him how he is feeling. And what took place after these calls? There was no follow up after these calls, and/or documenting how exactly Daniel had been feeling i.e. low mood and physical bloating. There was just no evidence of this within his records, despite him presenting with these mental health symptoms.

139. The Linden Centre took on a job to look after and care for Daniel. They had responsibility, and they had to do that job, but they didn't. I can guarantee that had there been continuity in care and proper engagement with Daniel, they would have understood and would have realised that Daniel had a serious mental health problem, that required inpatient care. However, when EPUT fail to engage Daniel properly and you get different people ringing him up, you don't get this. Continuity is crucial in the correct suitable care being provided and clearly Daniel was failed in this regard.

Staff, healthcare and other professionals communication

140. I simply was not involved with Daniel's care anywhere enough as I should have been. The Linden Centre had my telephone number, and Daniel had given them explicit consent (we signed all the consent forms) that they could communicate with me regarding his care. However, no one followed up. I would always explain that if for whatever reason they could not get hold of Daniel, that they should contact me.

141. I was not called by anyone from the Linden Centre once. There is evidence where EPUT apologise to me acknowledging that they should have called me, when they failed to contact Daniel.

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

142. I have mentioned earlier in my witness statement, that I had attempted to contact EPUT and the Linden Centre on multiple occasions to chase up what was happening with the brief intervention for Daniel. I also have explained how I complained to A, that Daniel was bloating and was not himself, to which I was informed Daniel would receive help, but his never materialised.

143. My impression of how my complaints and/or concerns were dealt with, was completely appalling. Everything I asked for in terms of help for Daniel was ignored. Even the EPUT secretary asked me after Daniel's death regarding my concerns, which I answered, and it went back to EPUT, and they didn't answer any of the questions I raised in the inquest.

144. On 11 January 2022, I went to the Linden Centre to advise the staff there, that Daniel had passed away. I was seen by A (Clinical Manager) and ANP f-2-f in a group room at The Linden Centre.

145. During my meeting, I explained that Daniel had called me at 07.30am on 10 January 2022 and wished me well for my medical appointment and said that he'd speak with me later. However, I explained that I did not hear from Daniel for the remainder of the day but decided not to call him as I had woken him before, and we already had plans to see each other on 11 January 2022.

146. I further explained that I had called Daniel 20 times that morning and had received no answer. As a result, I went to the property he was staying in and noticed that there was a curtain half open and could see that there was a light on. As there was no answer at the door, I went to the property management company and got a key; the front door was also locked from the inside. The property management company called a locksmith who drilled the lock. Thereafter, I explained that I entered Daniel's property first and found Daniel face down in some vomit. I got the locksmith to call 999 and explained to them what I saw and that he was warm to touch so they advised me to commence CPR on him, which I did for approximately 45 minutes.

Paramedics later arrived and they pronounced Daniel had died explaining to me that the high heat in Daniel's property had kept him warm but that my son was gone.

147. I told A that I did not feel Daniel had intentionally ended his life, but had purchased more medication than he usually would, as I had seen a large amount of medication packets around him. I also explained to A that the Police had said to me at the scene, that there was no indication that Daniel had taken any illicit substances. I also said that I had come straight to the Linden Centre from Daniel's property to speak with staff.

148. As you can imagine, I was very upset and angry having just discovered my son had passed and I let it be known that the blame for Daniel's death, was squarely at the door of the Linden Centre. I explained that if Daniel had been seen sooner and been admitted as an inpatient, this would not have happened. I also said that Daniel had been in and out of prison for much of his life and also using various substances but had been clean for the last few months and was hopeful that he would get the help he needed, as he finally understood he had mental health issues but that he would receive the necessary help.

149. I revealed to A that Daniel had been prescribed Pregabalin and Quetiapine but had also been buying both of these medication from drug dealers and using more than his prescribed dosage, stressing that when Daniel was given support calls from AAS, he spoke with staff and was struggling with his mental health but decided not to tell staff about the use of the additional medication for fear that his prescription would be stopped.

150. During the meeting I was largely in shock. I was told by A that EPUT's Patient Safety Incident (PSI) team would be made aware of Daniel's death and review his clinical notes to decide, along with his toxicology results, what steps would be taken next. However, my main pressing concern / question was around the length of time it had taken for Daniel to be seen by a Lead Practitioner and the poor decision to offer support calls by duty clinicians in the interim that the Lead Practitioner was not available. I asked A, if this was usual practice and staff explained (whilst acknowledging that they had not read Daniel's notes) that the Brief Intervention was running a waiting list and it was allegedly usual protocol to offer support calls in the interim.

After Daniel's death

How I came to be informed about Daniel's death

151. I have touched upon above how I found to find out Daniel had died. But to reiterate, on 11 January 2022, I went to visit his house and couldn't get access, so I called a locksmith. When the locksmith arrived, I went inside and instantly knew that something was wrong because the door was locked from the inside. Also, earlier that morning I had tried to call Daniel about 20 times, but there was no answer. Previously, I went around to his flat every morning, to check in with him. However, on this occasion, once the door was opened, I found him just lying there. I was immediately hysterical, and the locksmith rang for an ambulance, and then put the phone on loudspeaker and they were giving me instructions for resuscitation.

152. Once the paramedics turned up, they used a word, which I understand to be *'rigor mortis'* to confirm Daniel was dead. The Police then came, and this was the worst thing ever for me, as they were recording as though it was the scene of a crime. Daniel was covered in vomit, and I was trying to wash his face. The Police spoke to both me and the locksmith and took our witness statements. The coroner then came to the property, and also my daughters and then assistants from a funeral home put him in a black bag and took him away in a hearse.

The process after Daniel's death

153. EPUT did not tell me much if anything about what the process would be, after Daniel died, except for what they told me when I went to the Linden Centre on 11 January 2022, to let them know that Daniel had died, which was very little. EPUT did not say about carrying out internal investigations and/or preparing a serious investigation report and/or that an inquest would need to take place.

154. The coroner on the other hand, was fantastic and fully explained the process and what I should expect in relation to the inquest that was to take place.

155. In terms of support from EPUT, whilst they may have offered condolences on the day I went to inform them that Daniel had died, that went over my head and felt empty, as I was in shock that I had just lost my son. Furthermore, the condolences felt hollow, as I needed their help for Daniel, before he died. My son died and when someone says to you that if you need personal assistance with your mental health, or

if you're in a crisis, to contact NHS 111, you don't really take it in, you're grieving the person you've just lost. If the condolences and signposting from EPUT, was their attempt at a token gesture, then that is a joke. I was grieving and they (EPUT) were providing me with robotic responses.

156. Why would EPUT want to support me when my son under their care has died. If I've gone to Linden Centre to say my son has passed away, how does their hollow support really help me? I felt deep down and saw as though they had caused the death of my son.

157. I did everything myself after Daniel died. I went to doctors, had counselling, and because of my state of mind they put me on Mirtazapine. My girls even said to me *"dad you've never taken anything before."* As a result of Daniel's death, it was me that had to deal with everything and cope with the aftermath.

My observations in relation to communication, treatment and support

158. I had nothing in terms of communication, good treatment and support, in the aftermath of Daniel's death. The only people I felt were good and supportive, was the coroner's office, who were wonderful. A lady from the coroner's office spoke to me all the time and assured me that she said you would disclose to me the autopsy and toxicology reports, where I would have an idea of what Daniel might have died from. She then explained that after this process, an inquest into Daniel's death would take place.

159. Once the reports were complete, I was awaiting for the inquest to take place, however, we had to waiting on the documents from EPUT and the Linden Centre to send everything across to the coroner. However, if it wasn't enough that EPUT (Linden Centre) had failed in their duty of care to Daniel, they were now being obstructive after his passing, elongating matters, by delaying and causing what was an already traumatic experience for me. That was the worst thing after Daniel's death because it was like a cover up. As far as I was concerned, EPUT were going to get me all the information in their possession concerning my son.

160. The inquest kept getting delayed due to EPUT's actions. For example, the inquest date initially listed was cancelled due to EPUT's inability to provide the responses to questions I had asked of them, by the deadline provided. When this

happened, I was informed by the coroner's officer that she would contact EPUT to further relay my questions and another inquest date was set but cancelled again for the same reason. I was then contacted by EPUT, with a secretary, explaining that they were told to contact me due to concerns I had regarding Daniel's care. During this call, I relayed all my concerns and the questions I had, and I was told I would get a response in 2 weeks' time. When the inquest eventually took place, lo and behold, EPUT had not answered any of the questions I had asked, so my concerns were left unanswered.

161. One of my observations, relating to the inquest was that I did not have a solicitor, which I believe had an impact on the outcome, as a lot of the questions I had for EPUT, were not answered. Additionally, I was extremely disappointed that **A [I/S]** was not directed to be an interested person, in her own right, which meant **A** would have had to answer to decisions that were taken relating to Daniel's care.

162. When the coroner provided her conclusion as to how Daniel died, she recorded it as misadventure, which didn't mean anything to me. I am of the strong belief that had I been legally represented that the conclusion into Daniel's death would have been different, as a solicitor would have requested more documentation, that would have assisted the coroner and asked more probing questions, that would have identified more about Daniel's death.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

EPUT After Action Review dated 15 July 2022

163. The After Action Review (AAR) carried out on 15 July 2022 is of no use to me and does not reflect what actually happened to my son. Whatever they said in that review is after the event. From my perspective, they needed to say to me at the time: this is what happened, this is where mistakes were made, and this is what will change going forwards. Instead, there have been 18 months of heartbreak with no honesty, no accountability and no learning.

164. Daniel was under the care of mental health services at Linden Centre. He had taken an overdose and was seen at Broomfield Hospital. They knew he was under Linden's care. Despite this, there was no meaningful duty of care provided to him from that point until his death. There was no consistent person contacting him, only phone calls, even though they themselves recommended that he should be admitted. The

After Action Review acknowledges that it would have been better for Daniel to have a consistent person to speak to, but this was obvious at the time and should never have been allowed to happen.

165. The review itself is concerning. All of the names are redacted, so no one is identified as responsible. This feels like a cover-up. There is no transparency and no accountability. Someone must be responsible, yet the review does not even say who was involved. They are investigating themselves and coming to their own conclusions.

166. The review states that there was deterioration in Daniel's mental state. There was deterioration. A apologised to me and said they would sort it out, but they can say whatever they want in hindsight. At the time, nothing changed. Daniel was prescribed medication that left him half asleep. He often would not wake up until two in the afternoon, so he may not even have heard the phone when they rang. I told them to take my number and contact me if they could not get hold of him. They never called me. When I found Daniel dead on the Monday, I asked why I had not been contacted, and I was told they had written down that they would call me if they could not reach him. That did not happen.

167. The AAR also refers to letters being sent. These letters said that if Daniel did not make contact within a certain number of days, he would no longer need their services. That is completely wrong. The letter should have said, *"We have not heard from you, please contact us."* You cannot accept someone under mental health services, with the power to intervene, and then flippantly withdraw care because you have not been able to contact them. That is not how duty of care works.

168. I also dispute the statement in the review that support was provided to the family. Nothing was provided. They suggested counselling to me while I was grieving, but I did not want support for myself. That is what they should have been giving to Daniel. For 18 months after his death, they did not ask me anything and gave me no disclosure or answers about their duty of care towards my son. EPUT contacted me asking what I wanted to know and said they would answer my questions at the inquest, then later rang me to say they had already answered my questions. They had not.

169. The review mentions staff shortages and waiting times. You cannot have staff shortages in mental health care. There should always be cover. These are common-sense things that should have been in place already. They should not rely on agency

or bank staff who do not know the patient. Nothing meaningful has been learnt from this review, and nothing has changed.

170. I walked out of the meeting about the AAR crying, thinking about Daniel's death certificate. Why should they only learn from their mistakes after my son has died? The amendments or learning points should have been at the start of the review, clearly stating what should have been done differently. I found no value in the After Action Review. Everything about it feels farcical, and someone needs to be held accountable for what happened to my son.

Other investigations or legal proceedings

Inquest

171. When Daniel died, I was contacted by the Coroner's Office by email. They explained that there could be an interim death certificate so that Daniel could be buried, but that there would be an inquest. They explained what the inquest process involved and told me that it was not a criminal investigation.

172. The Coroner told me that the inquest would take place on a particular date and said that if I had any questions, I should raise them with the Coroner's Office first and they would put them to EPUT. I was told that the purpose of the inquest was to establish how, when and where my son died. I did not like being asked to explain Daniel's young life in a pen portrait because, in my view, his death was down to the Linden Centre, and I was very angry about that.

173. The inquest was repeatedly postponed. EPUT contacted me and said that they had received questions from the Coroner that I wanted answered, and they asked me to explain what I needed to know. They typed up my questions and said they would put them to EPUT. However, the inquest kept being put off because EPUT were not answering the questions. I repeatedly contacted the Coroner's Office to say that my questions had not been answered. The secretary at the Coroner's Court knew me by this point and explained what was happening, but the inquest continued to be delayed.

174. At one stage, I was contacted to say that the inquest could go ahead, but when the Coroner's Office reviewed the material, they realised again that my questions had

not been answered, and they said they would go back to EPUT. This cycle continued, and the inquest was put back three times because of this.

175. At the inquest itself, the Coroner told me to write down what I needed to ask and said that she would send the questions to the Head of Inquests and they would be answered during the hearing. This is where the process became farcical. The police officer who attended Daniel's flat was present and gave evidence about what he saw. I asked for A and others from the Linden Centre to be present. Instead, EPUT attended with a solicitor and a representative of the Trust.

176. The Coroner explained that there could be a conflict of interest because the solicitors present were from a firm she had previously worked for, and she asked me if I was still willing to proceed. I had already waited around 18 months from Daniel's death for the inquest, so I agreed to continue. I was told that I could not ask questions directly and that I had to ask the Coroner, who would then put the questions to EPUT.

177. I was not aware that this was how inquests worked. All of the questions I wanted answered were put by the Coroner to the EPUT representative. When I asked where A was, the Coroner put this question to him. He laughed and did not answer the question. He did not technically have to answer any of the questions.

178. I was not legally represented and did not realise that I could or should have been. I was told the inquest was not criminal, so I did not understand the importance of legal representation. If I had had a solicitor, I would have known what questions to ask and how to challenge the lack of answers. To this day, we still do not know why Daniel died or what he actually died from.

179. The Coroner herself was fantastic and was spot on in everything she said. However, the inquest process as a whole was farcical. None of the questions I raised were properly answered by EPUT, and it felt like a whitewash. I should have had my questions answered, and I was never told about the importance of legal representation or given appropriate support.

180. I was unhappy with the pen portrait and with how the conclusion was reached. I was asked to leave the room at one point while discussions were taking place about what Daniel died from. If you listen to the recording, you can hear them arguing about the cause of death while I was outside. When the conclusion was given, someone came to sit with me because they could see how distressed I was. I did not understand

why I was asked to leave while they continued to discuss matters about my son without me present.

181. The verdict recorded was misadventure. Even after the inquest, I felt that nothing had been properly explained and that none of my questions had truly been answered. The inquest had been delayed multiple times because the Linden Centre and EPUT were not providing answers. I went into the inquest believing that **A [I/S]** and her team would be there and that I would leave with answers. Instead, EPUT attended with a solicitor, and I was told I could not ask questions directly. The questions that were put on my behalf were not answered.

182. There should have been more support for me throughout this process. The inquest process left me feeling excluded, unheard and still without any clear understanding of what happened to my son or why.

My views / reflections

Raising concerns with other organisations regarding Daniel's care

183. Daniel's GP raised concerns about his mental health and his treatment. The GP was the person who referred Daniel to the Linden Centre. Whenever Daniel was feeling depressed, he would return to the GP, saying that the medication was not working. The GP explained that they could not prescribe further medication because Daniel was under the care of the Linden Centre and that it was for Linden to manage and prescribe his mental health treatment.

184. At one point, Daniel was told that he had left the GP practice, but the GP still recommended him to the Linden Centre because of concerns about his mental health. I intend to obtain Daniel's GP records, which will show these repeated concerns and responses.

What should have been done differently with Daniel's care

185. Most importantly, Daniel should have had one consistent point of contact within mental health services. He needed one person who knew him, understood his history, and was responsible for his care. Instead, he received inconsistent and fragmented contact, which meant no one truly understood his needs or deterioration.

Recommendations for Change

186. There are several matters that I believe are critically important and require change, to improve mental health care for individuals like my son Daniel.

First, contact with next of kin

187. There were not enough attempts to contact me as Daniel's next of kin. The Linden Centre clearly failed to properly record or use my contact details. EPUT records show that a support worker later had to ask the GP for next-of-kin contact details, despite Daniel having been assessed and despite me providing my phone number and explaining that I was always with my son. They also knew that Daniel was heavily medicated and would often be asleep in the mornings, and that calls should be made after 11am. These failures happened from the very start.

Second, continuity of care

188. Daniel did not have continuity of care. Support workers were off sick or absent and were not replaced, and random workers would call him. These calls felt robotic and meaningless. Someone of equal qualification and responsibility should always have been available to pick up his case. A social worker is not the same as a mental health worker, and continuity should not break down simply because someone is on leave.

Third, taking proper history from family members

189. I had extensive knowledge of Daniel's life, mental health and vulnerabilities, but this was not properly used. When I spoke to **A**, it was clear nothing effective was being done. On the Friday before Daniel's death, they called him, I lost my temper, and I was told it would be sorted out. It was not.

Fourth, honesty, transparency and accountability

190. I am deeply concerned about redactions in the EPUT records, particularly where Daniel was expressing distress or asking for help. It feels as though information has been removed because it makes the service look bad. Daniel was crying out for help and saying he was not receiving the support he needed. He was heavily

medicated and could not take in information properly, yet he was left without meaningful care. Calls contained no treatment content.

Fifth, the inquest process and legal representation

191. Where a death has occurred, especially where mental health services may have materially contributed, there should be legal representation present and full disclosure before the inquest. Families should not attend an inquest alone, with no one present from the service who can properly answer questions. Those who materially contributed to the death should be called as important persons.

Finally, the impact on families

192. When a child dies, a trust should not make matters worse by avoiding questions, withholding information or failing to be honest. I have been put through repeated trauma, with inquest after inquest being cancelled, little communication, and no clear answers. My son died, and I have been left to fight for the truth on my own. It feels like nothing has changed at the Linden Centre, and without accountability, nothing will.

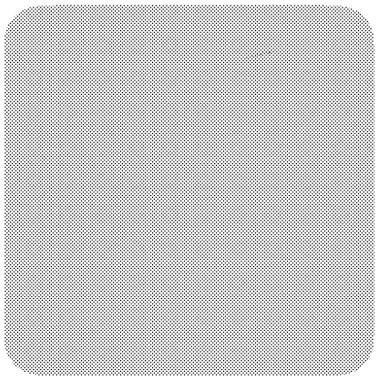
Statement of Truth

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

Signed [I/S]

Full Name:

Dated 9/1/26



List of Documents

I attach the following list of documents

1. Postmortem report
2. Interim death certificate
3. EPUT records
4. Mixed correspondence from EPUT, HMC and GP
5. Comments from Daniel regarding being unable to cope with various tasks
6. Letter of response to my concerns from EPUT dated 16th February 2023
7. GP records
8. Inquest recording