Witness name: Sonia Edwards

Statement No: 1

Dated: 17th November 25

THE LAMPARD INQUIRY

Witness Statement of Sonia Edwards

I, Sonia Edwards, will say as follows:

Preliminaries

1. My full name is Sonia Edwards.

2. I am making this statement in relation to my son, Christopher Mark William Irwin, who was born on 18 December 1988 and died on 2 May 2023. All his friends knew him as Teddy, because he was cuddly, joyful, and uplifting.

3. This statement sets out my understanding of Christopher's mental health history including his interactions with Essex Partnership University NHS Foundation Trust (EPUT). It will first provide a chronological account of the care and treatment he received, followed by personal reflections on various aspects of his care and treatment.

4. Unbeknownst to me, Christopher suffered from addiction from the age of 17. Over time this rewired his brain, leading to depression and making it impossible for him to be in control of any part of his life. He suffered secretly

from this for many years prior to his death. He was given an "Elastoplast/tick box" treatment for his depression and no service took a holistic approach to his difficulties. He died three months after he was discharged from an acute hospital ward, where both his and my request for him to be sectioned to an inpatient facility was ignored.

Christopher's background

5. As a mother who loses her child, you dissect every moment of their life to where you could have made a difference. Christopher was born in Brighton on 18th December 1988. He had a traumatic birth by C section, where the doctor's knife cut Christopher during the operation. After he was born he had breathing problems and was removed from me and put in special care baby unit. Unfortunately, due to hospital logistical problems, this was on the other side of the hospital, and I had very limited access to him and was unable to feed him directly for four days. My own anxiety due to separation and the recent spate of cot deaths nationally was not the best start in life. Christopher was a very demanding, unsettled baby. He was very settled while breast feeding but it was never enough. I fed him for nearly two years because he didn't like the bottle. He was a very unsettled sleeper and didn't sleep through the night until he was seven years old.

6. His father and I were separated early in Christopher's life, but always remained united about Christopher. His father lived in the United States until Christopher was around 17 years old. Christopher's father rang every day at seven o'clock in the evening. In hindsight this may not have been a good idea as it brought on an anxiety in Christopher to always get home for the phone call. Christopher idolised his father, [I/S] **I tried to ensure that I gave him a** structured and disciplined life.

7. Christopher was a very loving, kind and sensitive child. In Christopher's pre-school years, he wasn't happy if he was left, so I worked at the preschool with him. He needed things to be organised and he liked to keep himself busy.

Being an only child I always had a house full of young children to keep him occupied.

8. Christopher was a very attractive, kind, caring and honest young man who had energy that lit up a room. He was very sociable, and always had a lot of friends growing up. He met his best friend, **[I/S]** when he was 3 years old and they were like brothers. I looked after **that friend and his brother when their mother** went to work and went out. When **that friend** was about 5 years old, he was diagnosed with a terrible disease for which he was given a life expectancy of 12 years. Christopher would care for him, inject him, change him, and clean him when he could not do it himself. **His friend** was in a wheelchair but managed to live into his 30s. **His friend** died a couple of years before Christopher's own death, and this had a devastating effect on him.

9. Christopher was also very close to **his friend's** parents and saw them very much as additional family, with two parents and two children to play with. He liked to be occupied and found it difficult to be just with me. **His friend's father was like a** father figure to him for whom he had huge respect. When Christopher was about 12 years old, **his friend** moved to Hong Kong with his family. Christopher visited them soon after they moved and during his visit **his friend's parents had marital issues.** On his return, his personality seemed to change. I believe this, and **his awareness of those issues** had an impact on Christopher's mental health. His dream of living with an ideal family was shattered and he became angry and aggressive. I know this had a lasting impact on him, as the last time I saw him physically, he asked me if I thought **his friend's parents were still having marital issues.**

10. During school when Christopher was 17, he had work experience at Met Shopfitters. At this time Christopher moved in with his father as he had returned from America. Only recently I have found out that during his work experience he was introduced to cocaine. His personality changed and I thought he had got into the wrong crowd. Christopher was talented and after he left school he went to Portsmouth University to study architecture. During the second year he dropped out and went back to live with **his friend's parents. It** was during this time that our relationship changed and I didn't really

understand why. He took various jobs but things never really worked for him. He started to become more volatile and difficult, and moved in with his father who lived closer to the work he was doing. I tried to help him by employing him in my restaurant business many times, but it always ended the same way with him not able to do the job and then blaming me for the problems he had caused. It was the same story when his friends found him work. They also had to let him go because of he was not able to perform at work.

Christopher's mental health history

11. Throughout his adult life, my relationship with Christopher had been difficult both as a mother/son and in our working together. There were numerous incidents that just didn't add up in my mind to explain his behaviour. He was often aggressive, had extremely poor memory and I knew he was not always being honest. In hindsight I also think he was slightly bipolar and had ADHD. These disorders were undiagnosed.

12. In the autumn of 2021 Christopher was admitted to hospital, which I later found out to be due to two suicide attempts. At this point he admitted to being addicted to alcohol and cocaine. This was a complete shock to me, but was also the point when I started to understand the possible cause of the change in behaviour since he was 17 years old. My immediate action was to put him into a rehabilitation centre in Luton. This was not successful for reasons I will explain later in this statement, but what was found after his death was a diary written during his time at the centre, explaining in his own hand, exactly the truth of his addiction from his late teens onwards. I also found out from his close friends more detail of his actions and behaviour from their point of view.

13. Due to the shame of being an addict, people who suffer with this affliction will always hide their actions from everyone around them, especially their loved ones. No one really knows why people become addicts, but for those that do, the change it has on the brain has far reaching consequences for everything

they do in their lives. As the addiction takes hold, their actions become more and more volatile and incoherent. This was certainly the case for Christopher.

14. Christopher was never quite the same after he found out about **his friend's parents' marital issues.** This only compounded the sadness he felt for his close friends' demise. Alcohol made him more confident and outgoing, and to his friends he was the light and soul of the party, but this was to hide a desperate loneliness and loss of self-worth as his addiction grew. He changed hugely over time; his highs were very high and his lows were very low.

15. In his mid 20s he was diagnosed with depression, and I understand he was prescribed anti-depressants, which neither his father, nor myself, were aware of at the time. I don't know the full details but was told later the depression was partly caused by the inability to sleep due to the addiction to alcohol. This is common problem for alcoholics, and explains why he used to leave early from being out with friends to go home and drink large amounts of vodka to get to sleep. By the time he was in his late 20s, Christopher became more volatile. He showed anger towards me, and also caused trouble with his then-girlfriend. He did not seem mentally right. At this point, unbeknownst to me, he was still back and forth to the GP.

16. In his early 30s and certainly within the last two years of his life, things escalated. As described earlier, on two occasions during this time period Christopher attempted suicide by overdose. He was admitted to South-end Hospital and quickly discharged once he was medicated. He informed the staff that it was a simple "blip" and told them he was feeling better. I was never informed of these two admissions; I only found out afterwards from social media, as he posted on Facebook. In his posts he showed he was at the hospital and wrote words to the effect of, "I'm still here; I've done this to myself." It was an obvious cry for help. It was clear that Christopher's life was falling apart around him because of his addiction. His erratic behaviour had driven his friends away and in the months before he died, Christopher told me that during this period he was "off the walls" because of the combination of his medication, cocaine and alcohol use.

17. It was clear that Christopher had an alcohol addiction. Despite this, he told me he was not encouraged or offered help in relation to his addiction by his GP. For every appointment, he was given a different doctor. He would tell them he had an alcohol addiction and was depressed, and they would give him a new anti-depressant prescription. It was neither holistic nor effective. I do not know whether he was ever given therapy. What I do know is that as a result of his treatment, Christopher simply had no faith in his GP.

18. In February 2023, Christopher was once again admitted to hospital. This time it was directly related to his oesophagus. Christopher's problems with his throat never improved and instead simply got worse. He received no more treatment. Christopher had been missing for a day and I had rung everywhere to find out where he was. He was eventually found in his father's home, in bed, surrounded by his blood. His oesophagus had ruptured from the constant vomiting as a result of his alcoholism, and his whole body was closing down. He was taken to Southend hospital and admitted to the acute ward. I was told by several nurses that he was incredibly unwell and would be blue-lighted to Chelmsford for surgery. This never happened, and within a week he was sent home. He was simply discharged. I found out when I went to see him for a daily visit and he was not there. Nobody informed either me or his father. Furthermore, despite both his and my specific requests, he was not sectioned.

19. Christopher went back to the hospital with his father on two occasions after his discharge because he could not swallow or eat. Both times he was sent away with a milky drink that only made matters worse by bringing more bacteria into his throat which eventually killed him.

20. Christopher went to his GP with me several times. On one occasion, he came out of the room crying with desperation; nothing was being done to help him. He also went to see a dietician after the February hospital visit as he was blowing bubbles when trying to drink fluids. I asked the dietician to please go and explain Christopher's symptoms as this can't be right. The doctor didn't even come and see him. Christopher was getting weaker and weaker. I was

desperate. Whatever we tried, the doors were closed. We thought the doctors and dieticians were taking the right decisions. How wrong we were.

21. Throughout this period, Christopher lost most of his friends. Luckily he allowed me to be there, and for the first time since he was 12, I felt that we got our friendship back in the last few months before he died. I can be grateful for those last months and remaining the time I had with him. This time has made it possible for me to cope with his loss. During this last period, I promised my son I would save him. I was unable to do this, as I trusted the doctors.

Christopher's death and events thereafter

22. I last spoke to Christopher the day before he died. I asked him whether I could take him to the hospital because he was so unwell. He told me that he did not feel well and didn't want me to see him. He said that if he continued to feel this way the following day, I could take him to the hospital. I contacted his father as he only lived two minutes away and I wasn't happy how Christopher described himself. I then texted Christopher back to give him support and tell him that I and everyone loved him and we would fight this together.

23. On 2 May 2023, Christopher once again woke up in the night and started to cough up blood, just as he had done in February 2023. He left the flat, stumbled down the stairs, and died on his own on the pavement halfway down the road.

24. The morning that he died, I woke up and my body, and whole head felt something was different. I got a call telling me to come to Christopher's flat and immediately knew something was wrong. When I got there the road had been closed off. I ran to where his flat was and I was stopped by the police and was told I couldn't go any further.

25. As I arrived, I found out that Christopher died from his father. The police did not speak to me or give me any information. After the ambulance took

Christopher away, I asked the police in attendance where Christopher died. They simply pointed to a section of pavement up the road from his flat. I sat on the floor and sobbed, and nobody came up to me.

26. The police did not speak to me then, and did not contact me thereafter. All contact I ever had by anyone relating to Christopher's death was initiated by me.

27. I was asked whether I wanted to see his body. I was in such a shock that I initially did not want to. I then changed my mind and asked to attend, only to be told that there could only be one visit in the hospital morgue which had already taken place with Christopher's father.

28. I rang the police on many occasions, and had huge difficulties in finding anything out about the death of my son. Nobody was there to answer the call and when messages were left by me they didn't call me back. When I finally spoke to a police officer in charge I asked why was I not able to see my son where he was lying, I was told that I should not see him, and when I asked why, the officer said, "your son crawled to his death, and he crawled for a long time, and he was very cut up." I would have wanted to see Christopher any way but to be told this over the phone was very cruel and thoughtless.

29. The post-mortem report was only sent to Christopher's father and not to me. It said Christopher died of bronchial pneumonia. I inquired about a private post-mortem as I wasn't happy about the treatment that he got in hospital, but I was advised by the Coroner not to get a second post-mortem. It felt like even when he had died he was once again being branded as, "it's not worth looking into him further" because he was an alcoholic.

30. In my view the communication was very poor – there was a lack of empathy, care and consideration. It felt as though he was seen to have done this to himself. But everyone should have the same respect, whether they were murdered or killed in an accident.

31. I feel that at no stage was I given support after he died by anyone. My son's horrific journey was never taken seriously. He was terribly unwell, yet treated as an inconvenience, and after he died I just took his baton.

Reflections and concerns about Christopher's care and treatment

32. There is not one positive thing that I can say about Christopher's care and treatment; not one part to give any hope. I believe that there was neglect in every department, including in how addiction is categorised, in the lack of accountability, the lack of respect, compassion or kindness to Christopher or to me.

33. In this section I will set out my key concerns with his treatment.

Lack of faith

34. Christopher clearly had a lack of faith that he would receive the assistance he required. He did not trust his GPs, and thought they were simply different doctors all doing the same thing and not getting to the bottom of his issues. It felt as though the NHS was no longer a care system, but rather a tick-box exercise for those with addiction and / or mental health issues. It felt as though the whole system was a waste of time, with everyone simply trying to patch up the knock-on effect of what he was doing to himself and nobody dealing with the illness itself.

Inadequate assessment as a child

35. In my view Christopher had signs of ADHD and Bipolar disorder as a child, which should have been picked up at school. In his early years he needed everything to be exactly as he needed it to be, and if not it unsettled his momentum. If he had been assessed appropriately, possibly enacted by a teacher who had concerns about his personality, it would have given me more awareness of how to channel a more positive path for his future.

Inadequate engagement with Christopher

36. Christopher felt he was not listened to, during contact with the health service. He was clearly self-medicating with alcohol and drugs, and discussed his addiction clearly with any doctor he came into contact with. Yet he was just given anti-depressants. He was not getting better because nobody was helping him tackle the underlying addiction. His GPs would simply prescribe a new anti-depressant in the hope of patching up the current problem. He wanted to live, but was never given a comprehensive pathway of help to attack the complex problem of addiction that he desperately needed to cure. He wanted to live. He had everything to live for. He was an amazing human being.

Lack of engagement with family

37. There was a distinct lack of engagement by the health services with myself and Christopher's father. This brings up the subject of confidentiality. It is important for most patients who have control of their own lives even if they are gravely ill, but for addicts that have no control of their own lives it effectively blocks any help from relatives to engage with the medical services. This is a huge problem.

38. I went with Christopher to many of his GP appointments, including those that he did not attend. When he did not attend, I was unable to speak to anyone. If I could have taken those appointments instead, and spoken to them about the terrible things that he was doing to himself, I could have done so much more. I sent many emails to the GP describing Christopher's behaviour patterns, his addictions, and my grave concern of his demise. When I tried to engage with his GP, I simply did not get a reply.

39. I was also not listened to at the hospital. I had to force my view on the medical staff by taking the doctors and nurses aside myself and telling them my views and concerns. Nobody ever asked me for a history or context; I always had to make the first step. It seemed like there was no system in place for the hospital staff to take my view into account. The only response I would get was "we will write it down". I raised concerns for example about the fact that the

oesophagus surgery did not go ahead, and the fact that he was not sectioned despite his clear request. But I got no substantive responses. When you are an addict, you need support and cannot do it alone. And yet there was no space in the system for my input and support. This lonely experience felt like system failure.

40. I was never told, as Christopher's family and next of kin, how I could raise formal complaints or concerns.

Inadequate private rehabilitation centres [PCP in Luton].

41. This experience was appalling. I paid for this, and the Centre took one month of payment up front. There were numerous issues:

    a. Christopher shared a room with a boy who was having an affair with one of the psychiatrists at the Centre.
    b. I question the appropriateness of the treatment there – I read his diary after he died and saw he wrote down some of the questions he was asked whilst there. One question was "Do you think you could stop being an alcoholic" to which his answer was, "When I die".
    c. There was no family liaison. I was not allowed to speak to anyone there. This made Christopher even more disillusioned with the system.
    d. Christopher was allowed to discharge himself the day before he was meant to leave. I did not receive a call to inform me he was going to self-discharge. His father picked him up.
    e. There was no appropriate aftercare. These clinics should have guidelines in force that include an after care package for patients and their families.

During his time at rehab Christopher wrote this on the front of his folder:

'No words can tell of the loneliness and despair I find in the bitter morals of self pity. Quick sand stretched around me in all directions. I had met my match. I'd been overturned. Alcohol was my master.

42. Christopher lost respect for the system and thought it was just a money machine to take advantage of desperate parents. I agree.

Assessments

43. Following his two overdoses and hospitalisations, I believe he did have mental health assessments prior to discharge. He told the mental health workers that he was "fine" and that it was just a "blip". But his overdoses were clear evidence that he was mentally ill, and an addict cannot stop hurting themselves. Furthermore, whilst in hospital he would quickly sober up because they would give him medication to stop him from getting irritated. They don't prescribe that when you leave, and so he left hospital, within an hour of discharge he would need to self-medicate again.

44. Christopher was admitted for his ruptured oesophagus in February 2023. At this point, his life was in extreme danger. The doctors knew about his addiction, his suicide risk and poor liver function. He was physically and mentally unable to take care of himself, but instead of admitting him to start a supervised treatment program to bring him back from the brink, he was discharged. Christopher pleaded to be sectioned as he told them he would only go back to drinking again. Despite literally dying in front of the hospital staff, despite three nurses telling me how bad his situation was, despite the fact that he was unable to eat or swallow properly, was blowing bubbles in his throat and could not walk properly, Christopher was told that he did this to himself and was discharged without adequate help. It was a very effective death sentence.

45. The only action to Christopher's and my request for sectioning was that Alcoholics Anonymous came in and fell asleep on a chair beside his bed during his short hospital stay.

Treatment

46. I am critical of his treatment. There was no consideration or treatment for his addiction. Things like mindfulness and reading are not going to touch his illness. Action needed to be taken to help and tackle the extreme addiction which had taken hold.

47. Furthermore, the way he was treated for depression was also not adequate. Addicts are notoriously dishonest with their care as their main motivation is to feed the devil from within. He was given anti-depressants, different ones every time he saw a new GP at his surgery. And I question the appropriateness of mixing anti-depressants with the cocaine and alcohol that the GPs knew he was taking. He once told me that he locked himself into his wardrobe for two days because he thought there were people in his flat. It is clear that this mix was making him hallucinate.

48. Depression, alcohol, suicide and self-harm are all under the same umbrella. Alcohol and drugs bring you up, the depression brings you down, and your wiring is all over the place. They must be treated together.

49. In February 2023 Christopher was admitted to Southend Hospital. He had damaged his oesophagus and we were told the treatment was critical and that he would be sent by ambulance to Basildon for surgical repair. The surgery was not carried out, and he was allowed home with no explanation. He was struggling to swallow and was coughing up frothy liquids; aspirating the highly concentrated drinks given to him on discharge, as he wasn't able to eat. I feel this was a direct contributing factor to his cause of death (bronchial pneumonia), as anyone aspirating products like these would be highly prone to infection. His admission, and his treatment, or lack of it, was all about repairing his oesophagus, which in fact they failed to do anyway, instead of realising that he is there because he was an alcoholic and needed help for that condition above all others.

<u>Discharge</u>

50. I am not aware of any care plans following discharge; I was not consulted or sent any plans. But even if there were plans, those with addiction do not have the ability to see them through.

51. Christopher was never told, "If this happens, then call this number". He was also not given any community support that we know of. When he was admitted he was told it was a surgical emergency; he was then discharged without instructions. If he was not going to be sectioned, he should not have been sent home to live alone; he should have been sent home with someone to give extra support.

52. After he died, Christopher's father looked at his letter box and saw there were multiple unopened letters from the NHS. These were all medical follow-ups; I do not believe any related to his addiction or mental health. And in any event, sending letters to an addict is not going to solve any problems as they don't read them. In a life of chaos they were discarded with all the other unopened letters.

Stigma of addiction

53. Addiction is an illness of the brain, which should be treated as such. It is not something one chooses. It is a disease that some people cannot stop, as there is a chemical imbalance in their brain. They need to be helped to remove them from their addiction, treated with compassion and given the help to recover. This takes time and recourses. Tragically for those afflicted, addiction is a disease that is looked down upon, and stigmatised by people who do not want to understand it. It is seen in society as a self-inflicted problem.

54. The stigma of societies' attitude to addiction is also mirrored in the health service. Even though you would have thought the health service would be made up of people whose main interest is to help the sick and ill, addicts are looked down upon. I have seen this not just from my experience with Christopher, but also any time I have been to A&E in Southend, where I see that addicts and alcoholics are spoken to and treated in a way that is

appalling. Christopher too, was treated like a leper, a second-class citizen, and more or less kicked out of hospital to die.

Recommendations

55. I would like the following recommendations to be considered:

a. Addiction is a pandemic. The condition touches directly or indirectly the majority of the population in some way. Addiction affects more than half the admissions to A and E in hospitals, is rife in the prisons and is widespread amongst the homeless. But these visible addicts are only the tip of the iceberg. Much of addiction is also hidden behind closed doors. Families and individuals suffer in silence, making their lives a misery and their productivity in the workforce poor. The government needs to treat the condition as a national crisis and try to help all of those who suffer.

b. We need to remove the shame related to alcoholism and addiction. Societies' attitudes need to change. Education, especially in schools is vital. For example a weekly life class from primary school and senior schools and in colleges to help if you are having problems.

c. There should be a formal mental health diagnosis of "addiction". It's a wide subject and needs a tailored approach.

d. Addiction should be a subject with its own department within the medical service, just like oncology. Treatment programmes and drugs to help patients should be made available at all stages in the addiction timeline. They are very different, depending on the case, but this needs to be assessed correctly and understood quickly to avoid premature death.

e. Families need a voice, and the subject of confidentiality needs review. Within the framework of the hospital, families and friends and loved

ones should be involved from the first admission. They should have an option of being informed about everything and be fully involved in the rehabilitation process. This is paramount to change, especially for addiction where you are at your weakest and alone.

f. Money taken from taxes on alcohol should go back into the problem to help people. Alcohol is glamorised, but it is a killer. There needs to be an understanding of what it does to the body and the brain, and this could be done through public health warnings similar to smoking.

I believe the facts stated in this witness statement are true.

Signed: **[I/S]**

Dated: 13th November 25.