Name of witness: Y15
Statement No: 1
Date: 1 October 2025

LAMPARD INQUIRY

RULE 9 WITNESS STATEMENT OF Y15

I, **Y15**, WILL **SAY AS FOLLOWS**:-

1. I make this statement further to a Rule 9 request from the Lampard Inquiry in relation to treatment provided to **[R/O]** David Cannon, whilst he was under the care of South Essex Partnership University NHS Foundation Trust ('SEPT'). **David** died in Basildon hospital on 6 February 2014, age 77. I make this statement from my own memory of events, knowledge, and belief.

2. It is important that I note that since being granted core participant status on 13 December 2024, I have asked the inquiry to obtain copies of the available records held by SEPT regarding **David's** admission, care and treatment on Meadowview ward between 30 December 2013 and 5 January 2014. At the time of preparing this rule 9 statement, I have not received any documents, nor do I have any documents that might have been kept by my family members. We collectively have no records in relation to the above in our possession. In particular, I require:

    a. All observation records;
    b. All care plan, risk assessment and falls risk assessment records;
    c. All assessments conducted by the ward doctors, psychiatrists, physiotherapists and/or any other specialists who assessed **David**;
    d. Records relating to any diagnoses made;
    e. Records regarding **David's** medication and any changes made to his medication during his stay;
    f. All written communications by and to Senior Sister **[I/S]**, Deputy Sister **[I/S]**, **[I/S]** and **[I/S]** regarding **David's** care and **his wife,** Evelyn Cannon's complaint;
    g. All written communications by all other staff members who were involved in **David's** care and treatment;

h. All minutes of meetings held between staff members regarding [R/O] David's care and treatment;

i. Decision records relating to the unnamed Agency Nurse mentioned in Senior Sister [I/S]'s letter of 22 January 2014 who was banned from working on Meadowview ward following my family's complaints;

j. All records considered as part of the investigation into Evelyn's complaint of 14 January 2014, including but not limited to any accounts taken by staff members who were involved in David's care and treatment; and

k. Any other records held by Meadowview ward and Basildon Hospital pertaining to David's care and treatment from 30 December 2013 up until his death on 6 February 2014.

3. My request for documents has been acknowledged by the Inquiry Legal team. At the point at which I am provided disclosure, I would like to be given an opportunity to submit a supplementary statement addressing the evidence and making further, more informed observations about what they show regarding [R/O] David's care and treatment.

4. As is outlined in this statement, my family and I believe the circumstances surrounding David's death are extremely serious. They concern unexplained events that caused him to suffer severe bodily injuries which, in our view, directly contributed to his rapid cognitive decline and eventual death, and all of which occurred in a short span of time whilst he was under the care of SEPT. Despite my suspicions about the events that led to David's passing, I have never been given any records from the ward responsible that might explain why this happened to him. Evelyn who was David's primary carer and support at home, has also now passed away and having checked her property since her death, I am aware that she had no documents pertaining to these matters either.

5. I believe David's case ought to be the subject of a closer forensic examination by this inquiry if it is to fulfil its Terms of Reference, it is a case that fits firmly within section 2(a) and (d) of the Terms of Reference, and may in fact be illustrative of an overarching and troubling theme regarding the poor treatment of older adult patients within Essex inpatient units. To be clear, the events outlined in this statement involve the suspected physical harm and/or neglect of David whilst he was under section, the falsification of records

after the fact by members of staff and the subsequent defective investigation into my family's complaint of the same.

6. I am aware that these claims are serious, however they cannot be credibly refuted without proper consideration of the records, which I have never been given the opportunity to review. To this end, at paragraph 86 of this statement, I have included a full list of the records I would like the inquiry to obtain on my behalf.

7. [R/O] David Cannon, was born on 2 November 1936 and died on 6 February 2014 at age 77. He died from dementia and sepsis according to his death certificate whilst he was in palliative care at Basildon hospital. His death occurred six weeks after he was first sectioned at Meadowview Unit in Grays, Essex.

8. I think David was first diagnosed with vascular dementia in early 2013. Unfortunately, I cannot be any more specific as to the date of this diagnosis because the inquiry team has not disclosed the records I have requested, and [R/O] Evelyn who would have likely known has passed away.

9. I saw David regularly throughout that year, and whilst his dementia was certainly evident, primarily in the way it affected his speech, he still remained independent. He could catch trains unaided to football matches at Leyton Orient and back and would make a trip every morning to the local shop to buy a newspaper and make it back home with no problems. He enjoyed watching television, spending time with his family and could converse with us and make jokes. Evelyn says quite clearly in her complaint letter to SEPT dated 14 January 2014 that before his section, David *"had been coping well with his condition for a long time"* and that his condition did not *"impair his ability to live a normal life"*.

10. In terms of his symptoms, he found it difficult to remember words he was looking for in a sentence, even though he was still very capable of sustaining conversations. As a result, we all simply adapted to his needs, often by giving him options to reply "yes" or "no" to. For example, if he could not remember the word for what food he wanted to eat, we would give him a list of choices and he would reply "yes" or "no" accordingly.

11. His symptoms did worsen towards the end of 2013; he began suffering hallucinations in the evenings which we were told was known as 'sundown syndrome'. He would also on rare occasions be unable to recognise **Evelyn**, though this was transient and infrequent. On a handful of occasions he fled the house, believing he was being chased and **Evelyn** had to call the police.

12. However, even by the end of the year, there was never a question of **David** not being able to comprehend things or be capable of self-reliance, aside from the occasional sundown hallucinations it was mostly a matter of him struggling to communicate the things he wanted, which is an important distinction to make in light of the decision that was made to detain him under section on 30 December 2013.

His section under section 2 MHA

13. In the more recent months before his detention, his hallucinations, whilst infrequent, became more troubling and **Evelyn** would sometimes find it difficult to cope. According to her, the hallucinations would usually take place in the evenings after he woke from what appeared to be a bad dream, he would wake up agitated and frightened and, in that state, would claim he needed to leave the house. He could sometimes leave in a hurry and **Evelyn** would not always be fast enough to stop him, and on the occasions when she did try to stop him, he could become irritated or frustrated with her.

14. The incident that led to his section took place in the evening of Sunday 29 December 2013; **David** suffered a hallucination and then left the house and walked to his local police station to report that people were after him. The police soon returned him back home to **Evelyn**.

15. The next day, on 30 December 2013, he was back to his usual self. However, **[R/O]** **Evelyn** had informed her social worker, **[I/S]**, of what happened and **[I/S]** **the social worker** decided she would need to visit the house to do an assessment of him to ascertain whether he needed to be sectioned.

16. A family member then received a call from **Evelyn** who was obviously shocked by the suggestion of a section for **David**, as we all were, especially given he was back to his usual routine already and was behaving completely normally. **Evelyn** **told my family member** that the social worker was talking about sectioning him, so out of

concern we all rushed over there to see what was happening. [R/O] [R/O]

17. When we arrived, the social worker was already there. I went to sit with [R/O] David on the sofa in the living room. There was nothing concerning or erratic about his behaviour, he was calm and chatting with us as he usually did. In fact, as Evelyn recounts in her complaint letter, he was in a great mood that day, making jokes with everyone:

> *"That morning he had left the house, bought a paper, returned home and read it. [R/O] all visited the house that day and he spent several hours engaging in normal conversations with all of them, asking and answering questions and making jokes, as usual…"*

18. In contrast to *his* behaviour, my memory is that the social worker was the only one who behaved appallingly that day, and frankly, my family and I hold her responsible for instigating the chain of events that led to David's death.

19. Her actions, at least in part, also appeared to be motivated by malice. [R/O] David was no longer exhibiting any of the previous evening's symptoms which had triggered the social worker's visit in the first place, so a family member decided to have a quiet word with the social worker to ask that he not be sectioned that night. He had been chatting away about how much he was looking forward to our family New Year's Eve party the next day and we knew it would devastate him and us if he was taken away before it happened.

20. In response to the request, the social worker smirked right in my family member's face and sarcastically said '*Hmm… I think I will!*' and then walked off into the kitchen to speak to Evelyn. Ten years on, I still remember my family member's clear distress at this interaction and struggle to comprehend why the social worker was so nasty to her; it seemed to be an act of purposeful cruelty without any reason or justification. It felt extraordinarily spiteful and gave the impression that she was enjoying inflicting pain on David and his family. My family member was and still is distraught by this. It may be that the social worker's role is outside the remit of this inquiry, however the mental health assessment that David was subjected to that day was at her behest and was the determining factor for his section, so I have mentioned it here in case there is room to examine her

behaviour and decision making. In our view, that social worker's conduct should have been investigated.

21. Two doctors came to the house to conduct **David's** assessment; they asked him questions along the lines of *"What is the date today?"* and *"Who is the current Prime Minister?"* **David** struggled to answer these questions, however it was unclear whether this was because he did not know the answers or because he could not get the words out, as I mentioned before, the struggle to find the right words formed a big part of his symptoms. Clearly, he *had* known the date in earlier discussions with us as he had been excited about coming to our house the following day for a New Year party.

22. Regardless of the reason, he did struggle to answer the questions but I also question the relevance of such questions in a detention under section decision in any event, I believe there would be many dementia patients that would struggle to answer questions like this without it triggering a need for involuntarily detention. Why was his not remembering the name of the then-Prime Minister, at 77 years of age, grounds to forcibly remove him from his home?

23. Nevertheless, the decision was made there and then to section him. **Evelyn** later said about this decision in her complaint letter:

> *"The two doctors told me that the reason my husband was being sectioned was so that they could monitor him for 24 hours per day and try to work out what was causing him to suffer these hallucinations, which usually occurred in the early evenings. The doctors said once medical staff had discovered the cause, they would try different medications and monitor my husband around the clock to see how he reacted to them, hopefully settling on a particular course of medication which would minimise these symptoms and allow him to return home swiftly."*

24. This idea that it was only temporary and for the sole purpose of correcting his medication corresponds with my own memory from that day too. They told us the section could legally last only 28 days and that he was being admitted as an inpatient to try out different medication under supervision and that once he was settled he would be able to come home.

25. I was not aware then but understand now that this type of arrangement accords with a detention under section 2 of the Mental Health Act 1983.

26. The details of the section, what it meant for him and particularly that it was compulsory and involuntary, were never explained to David by the social worker or doctors. He was given only brief details and to my understanding, had no previous knowledge about what a section actually was. It is my opinion that he, and we as a family, were deliberately misled as to the nature of the detention.

27. Evelyn recounts in her complaint letter that David even volunteered to go to the hospital himself, but the doctors refused, telling him that people often changed their minds once they arrive so the section was the best way to ensure he received the help he needed.

28. Once the decision was made that he was going to be sectioned, we had to wait several hours for an ambulance to arrive to transport him. The delay was because of an ambulance shortage at the time. One of the doctors remained at the property with us. We were all feeling anxious about the wait and after learning at some point that it was going to be several more hours, we decided to ask if we could take him ourselves in our own vehicle. They agreed so we drove [R/O] David there following behind the doctor in his car to the location.

29. We arrived at Meadowview Unit, Thurrock Community Hospital in Grays, late at night on 30 December 2013.

Meadowview Unit

The ward environment

30. Not only did I have concerns about the basis for the decision to section [R/O] David, I also had real concerns about the ward environment too. When we arrived, we immediately knew the place was unsuitable for him.

31. David knew it too, when he saw how mentally unwell a lot of the other patients were he became incredibly distressed and his reaction was not unreasonable. His condition was nowhere near as bad as the other patients we encountered there.

32. I refer to Evelyn's account of what happened when we arrived, which accords with my own memory:

"Once we arrived at Meadowview late that night, my husband did not like the hospital and became extremely upset. While his symptoms manifested themselves infrequently and he was mostly fine, many of the patients there were clearly in more advanced and acute stages of dementia. Within moments of arriving, one patient began trying to pull our table away from us while we waited to speak to medical staff. Another sat beside my husband and began speaking to him in tongues, while another started picking up and fiddling with my husband's belongings. I could see that this unnerved my husband and he began asking to leave. Once my husband realised he was being kept at the hospital whether he liked it or not, which had not previously been explained to him, he became very angry. While he certainly became a handful, arguing with the nurses and attempting to leave, nobody could deny either his physical fitness, his coherence or his eloquence. He was of sound mind and in robust health when we left him."

33. At the point at which **David** realised he was being detained involuntarily, he became terrified and furious. **Another family member came to me and another family member panicked** saying the doctors were now backtracking on the information we had been given at the house; the maximum detention of 28 days had suddenly become 28 days '*at a time*', a situation which could seemingly reoccur in perpetuity. When we heard this, we felt we had been tricked and lied to. It had been presented to us at the house as though 28 days was the absolute maximum, but that it was more likely to be something like a week – just long enough to get his medications right. None of us were more distressed than **David** though, I remember him looking at me and asking if we could take him home. He looked petrified. As I explained to him that we couldn't, I burst into tears. I felt immediately like we, his family, had been duped into letting them take him away like a prisoner. He began panicking, trying to escape and angrily shouting that we had all tricked him.

34. For most of us in the family this was the last time we ever saw him as a communicative human being; the last interaction we ever had with him was witnessing him completely petrified, in fear for his life, hammering his fists on the doors and windows of Meadowview, screaming at us that we had betrayed him and were leaving him there to die.

35. I vividly remember being in tears, standing on one side of a window whilst **[R/O]** **David** was on the other side, locked behind it, pounding on it with his fists,

screaming "Y*ou call yourselves family!?"*. It was unbearable to know that he felt we had been complicit in something we also felt was a false pretence and altogether unnecessary. Leaving him there and watching him panicking was one of the most horrific moments of my life and still upsets me to think about – not least because he turned out to be right: we *had* driven him to his death.

Staffing arrangements, training and support

36. Visitation was another issue. I along with other members of my family were told by staff at Meadowview that we should not visit **David** as we would only be reminding him of the outside world when he was already being detained against his will. We were told it would do more harm than good and it would be better to leave him there without visitors, so he could adjust. We were naturally torn between accepting what we considered was expert advice by medical staff, versus trusting our own strong instincts not to leave him terrified without visitors. We were sceptical of the advice as we feared it could contribute to his impression that we tricked him in order to lock him away.

37 **I do not remember on what date but a family member** was the first person to defy the advice and visit **David**. **He** described him as seeming agitated and pacing the hallways as if looking for an escape route. This was the first of only two visits **David** would receive before he suffered serious injuries on the ward under mysterious circumstances.

38. Other than visits, I do not remember any of my family speaking to **David** on the phone whilst he was there, I do not believe we had a number for him and he certainly would not have known anyone's number to make a call himself.

39. As I was not directly involved in **David**'s daily routine, I have no real knowledge about events that may or may not have taken place whilst he was on this ward. I am aware he stayed there between 30 December 2013 and 5 January 2014, however I have been asked to cover topics within the rule 9 request that I am not aware of the answers to, such as the following:

    a. Whether staff kept **[R/O]** my family uptodate on how he was doing on a daily basis;
    b. Whether staff kept my family uptodate about his medical assessments;
    c. Whether staff kept my family uptodate regarding his existent or any new diagnoses that were made;

d. Whether staff kept my family uptodate regarding the changes to his medication – which, again, was the reason we were told he needed to be sectioned in the first place, i.e. to be monitored under supervision;
e. How David was eating, sleeping, interacting with staff and other patients on the ward;
f. What therapeutic activities were being offered to him that he was or was not participating in;
g. Any information regarding his care plans, risk assessments or any mental health assessments he underwent;
h. Whether anyone in my family was invited to any review meetings to discuss his progress;
i. What observation levels he was on at any given time;
j. Whether assistive technology was in use in his room;
k. What any falls risk assessments were of him at any given time; or
l. The extent of any issues that occurred regarding David's stay.

40. Again, I have been given no documentation that might assist me in addressing these points or identifying any concerns or gaps in his care, or to the contrary, identifying any positive staff interactions with David that might have occurred. At the point at which I am provided with records, I would like to address these points in more detail. Nevertheless, I do know that we later discovered that staff had been fabricating at least some of the observations they were supposedly conducting of David in his records. I know this because we confronted the Senior Sister when she read out a few observations at a meeting we had with her, which we knew were false because they concerned the time of the second family visit David received, and did not accurately recount what he had been doing at that time. I will come onto this shortly.

41. With that in mind, it would not be farfetched for me to believe that the ward staff were not in fact keeping my family informed about David's progress, or were not being forthright about his condition and general health, and/or failed to invite my family to any review meetings. In fact, I am almost certain that this was the case because of the shock we all had on 5 January 2014 when we saw David in hospital with injuries that none of the staff could clearly explain.

Visits and emergency hospitalisation

42. The day before, on Saturday 4 January 2014, some family members went to visit [R/O] David [R/O]. On that occasion, David was reportedly much calmer and so was able to spend several hours with them chatting and enjoying the company. I recall that a family member was so thrilled when she heard about his state of health that she decided she would visit him the next day. To be clear, David at the visit on 4 January was physically well and had no bruising on him.

43. Suddenly, the next morning, Sunday 5 January 2014, Evelyn received a call to inform her that David was being transferred by ambulance to Basildon Hospital. I found out about it when Evelyn called the house and spoke to [R/O] a family member to tell her. I did not attend but other family members rushed to the hospital to see him.

44. When the family member arrived, she was aghast at what she saw. David was covered from head to toe in dark bruises, he had bruises on the front of his body, the back of his body, the sides of his body and even on his inner thighs. He also had a black eye and bruises around the tops of both of his arms which appeared as though he had been violently grabbed by someone. He was shaking uncontrollably, and groaning, and was unable to communicate verbally. My family member was gobsmacked and horrified.

Agency staff member

45. David had been accompanied to the hospital by a member of staff from Meadowview ward who spoke to the family member and questioned her aggressively about who she was, and then refused to let her speak to David without them being present. The behaviour was appalling, but it made little difference because David was incapable of any verbal communication anyway. Evelyn arrived and saw the same thing and says in her complaint letter that she was *"shocked and dismayed by what [she] discovered".*

46. The next several days are important to recount because different members of my family had discussions with the Meadowview staff about how on earth [R/O] David sustained his injuries, and the accounts suspiciously kept changing:

    a. At the hospital that first day, the Meadowview staff member on site that was unpleasant to the family member told her that David had **fallen out of a chair**. I remember being told this, because I specifically remember my

family member saying that she replied with words to the effect of: *"Really? How many times did he fall out of it?"*

b. At some point later but still in those first few days of his hospital admission when there were different staff members in attendance on different days, it was mentioned that David might have had a **seizure**, and that this was how he sustained his injuries.

c. Evelyn then records in her complaint letter from 2014 that she telephoned Meadowview ward during the first week of David's hospital admission and asked how he had become covered in bruises, she says:

> *"She told me that he had **fallen out of bed and may have suffered a seizure** but also told me that there had been **mattresses** on the floor beside his bed specifically to cushion his landing if he fell out of bed."*

47. What became clear, is that the stories were never the same; first he had fallen out of a chair, then out of his bed, then out of his bed and suffered a seizure, but wait, perhaps not because there was a mattress on the floor that was supposed to minimise any injuries he could have sustained from a fall? Regardless, none of the explanations seemed to any of us to explain the sheer extent of the bruising David had suffered on all sides of his body and the matter was so obviously serious that one would think an internal investigation would have been done to ascertain the facts.

48. We continue to be unable to accept the unsubstantiated claims that David's head-to-toe bruising was caused by him either falling out of a chair or from his bed, for the following reasons:

a. Firstly, what kind of fall from minimal height would cause bruises to the face, hands, tops of the arms, front, back and legs? In my opinion, if he had actually fallen out of a bed or from a chair, the bruising would predominantly be on the side of his body that hit the floor, not all over his body;
b. The explanations also do not account for why he had bruising on his inner thighs, that is not usually caused by falling from a chair or out of bed;
c. The bruising was also far more severe than one would expect if he had in fact landed on a mattress;

d. I also find it hard to believe that **David** suffered from a seizure because, and **Evelyn** confirmed this, he never suffered with seizures before his admission to Meadowview ward, so why would he suddenly start having seizures? And even if he had, why was my **family** not informed about this?
e. And even if he *did* have a seizure, I would like to know what was happening that might have triggered this?
f. And if he *did* have a seizure, it still does not explain why he had bruises all over his body, particularly if he had fallen on a mattress.
g. Finally, and most obviously, if it was not something nefarious that occurred, why did we get several different versions of the story about what happened to him?

49. **Evelyn** goes on to recount in her letter that Meadowview also blamed the bruises on **David** having leukaemia, which **Evelyn** also found hard to believe:

> *"She [the ward manager] suggested that because my husband suffers from a form of leukaemia he may have bruised more easily than other people. This has never been the case in the past and when I asked the doctors at Basildon Hospital, they told me there had been no change in my husband's blood since his last test several months previously. In that time, he had shown no signs of bruising easily. Therefore, I cannot accept this explanation."*

50. Ultimately, I find it hard to fathom that a single fall (from either a bed or chair), caused such an impact that **David** suffered dark bruises to all sides of his body, face, arms and the insides of his thighs. Rather, this type of bruising, to me, was more analogous to him being involved in a prolonged incident with multiple impacts. On the contrary, we were deeply concerned that his injuries were consistent with him been roughed up by staff at Meadowview, perhaps because he was non-compliant again, trying to resist treatment or escape. We were so **concerned about the injuries that a family member** took contemporaneous photographs of **David's** bruises at the time. I have included mention of these photographs in my list at APPENDIX 1 of this statement, and would be happy to provide them to the inquiry upon request. Please note that by the time **my family member had taken the** photographs, **David's** bruises had lightened in colour and so were not as prominent as they were initially but were still clearly all over his body.

51. Unfortunately, David was never able to tell us the truth about his injuries and how they occurred. He never regained his ability to communicate after this incident. He became a quivering wreck; he shuddered constantly and made noises as though he was petrified and wounded. Alongside the lack of a clear explanation as to how he sustained such horrendous injuries, there was also no clear explanation as to why he had suddenly and completely lost his ability to speak or properly control his body.

52. David had been under the care of Meadowview for only six days and in that time, he had deteriorated to such an extent and at such a pace that nobody would believe it unless they saw it themselves. He entered that ward as a happy, independent, communicative man struggling with a few dementia symptoms, and he exited it mere days later as a jabbering, shuddering husk, who never managed to speak a word of sense to any member of his family again. He would sometimes blurt out a word, but with no context or clear intent.

53. Upon visiting David at Basildon Hospital in the week after the incident, I was able to see his bruises for myself and although he could not speak, he did respond to stimuli – on one occasion when he was shaking and groaning, I started talking to him, telling him I was there with him and that I was going to do my best to find out what happened to him, and I remember he noticeably calmed down. On Friday 10 January 2014, a family member visited him and mentioned in his presence how he got his injuries from falling out of bed and he became agitated and appeared to be gesticulating as though he was trying to tell her something that he was incapable of verbally communicating.

54. David was also still under section at that time, so different nurses from Meadowview would attend to watch him in his bed at Basildon Hospital. At some point though, I believe less than a week into his hospital stay, they stopped attending and he was thereafter left in the care of the hospital ward he was on.

55. Over the coming weeks, David's condition severely deteriorated. He lost his ability to eat and swallow; he became increasingly malnourished and was agitated all the time.

56. There came a time when I had to stop visiting for a while because of a respiratory bug I caught that I did not want to pass on to him. I stayed away for some weeks to recover. When I finally did visit again, which was about a week before he died,

so late January 2014, I was horrified by the condition I found him in. He was skeletal at that point and barely recognisable; he was so emaciated that his cheekbones and teeth were jutting out. One of his eyes was also discoloured and looked as though it had effectively stopped working. I did not even recognise him when first I saw him.

57. I burst into tears, I just knew he would not survive this. Although he was awake, he appeared to not know where he was or who he was, he was like a baby looking around confused. The deterioration in a couple of weeks was extraordinary; he went into state care with dementia, a relatively mild form of it where he could still laugh, make jokes, watch television, walk and eat by himself, but mere weeks later he was emaciated, incapable of communication and had completely lost control over his bodily faculties.

58. **Evelyn** was so devastated that she decided she needed to write a letter to Meadowview about **David**'s shocking decline, so she dictated the letter and I typed it up. This became her complaint letter of 14 January 2014 that I have included in my list at APPENDIX 1. In the letter, **Evelyn** talks about her experience after seeing **David**'s injuries:

> *"As I write this letter more than a week later, my husband is still almost completely unable to verbally communicate. He entered your facility as somebody who had spent the vast majority of the Christmas period surrounded by family, communicating freely with friends and relatives. Within six days of entering your facility, he has deteriorated to the point where he cannot speak more than a few words at a time and now largely speaks in tongues. To date, nobody has been able to give me any explanation as to why his speech has deteriorated so quickly or whether there is any hope of him regaining his speech. In addition to losing much of his ability to communicate, he now spends several hours every day shaking, clawing at his bed sheets and groaning, occasionally managing to utter short sentences, such as 'Help. Help.' or 'Please. Please.' To date, nobody has been able to give me any explanation as to why he is doing this or whether there is any hope that this will subside in the future."*
>
> *I am heartbroken by the change in my husband during the six days he spent at your facility. I was convinced that by agreeing to the section I was doing the*

right thing, but within days he had deteriorated to the point that he was no longer the man he had been when I left him at Meadowview. He entered your facility as somebody who, 95% of the time, was perfectly fine. Doctors told me he was going to Meadowview to be treated for the 5% that was wrong. Instead, he has emerged as somebody who, if we are lucky, is coherent for a few brief moments of each day. The deterioration has been sudden and seismic. I cannot accept that this is merely a coincidence. He had been coping well with his condition for a long time. There was no reason why he should change so suddenly and so severely. I feel deeply aggrieved not only by the vast deterioration in my husband's physical and mental health but also by the lack of explanations forthcoming from the staff at Meadowview. More than a week after his transfer to Basildon, I still have no legitimate explanation as to i) how my husband sustained bruises all over his body, ii) why he has suddenly lost his ability to speak or iii) why he now spends several hours of every day shaking uncontrollably, clawing at his bed sheets and groaning."

59. Clearly, this was a serious incident that merited a thorough investigation. **Evelyn** made clear she wanted to know how this could possibly have happened.

Meeting with Meadowview staff members

60. On 16 January 2014, **Evelyn, another family member** and I, attended a meeting at Meadowview Unit which was arranged at our request following **Evelyn**'s complaint. We met with Senior Sister **[I/S]** and Deputy Sister **[I/S]**.

61. **Evelyn** brought a list of questions with her and as she went through them, **[I/S]** **the Senior Sister**, who was leading the meeting, responded that she was not going to be able to give us any answers because she and Sister **[I/S]** were not directly involved in **David**'s care. That really set the tone for the meeting - it quickly became abundantly clear that it was going to be useless.

62. One of the more stark moments, from my memory, was when **the Senior Sister** told us she would read out the logs where all staff observations of **David** had been recorded. That was when we discovered, as mentioned at paragraph 40 of this statement, that the observation records had been fabricated, at least partially. We asked her to read the logs from the days leading up to his hospitalisation so that we could get an understanding of his movements before he was injured and part way through her doing so, **my family member exclaimed** that the records were fake. **[I/S]**

The Senior Sister was reading out the records from Saturday 4 January 2014, which was the day he visited David with two other family members [R/O]. The records the Senior Sister was reading out were timestamped (i.e. something like *"at midday, Mr Cannon was observed doing this, at 1pm, Mr Cannon was observed doing that"* and so on). My family member had suddenly realised that these records reflected the several hours he had spent personally sitting and chatting with David, yet the entries made no mention of David having visitors and instead described him being involved in other activities in other locations on the ward.

63. The records had categorically been fabricated, and clearly no investigation had been done by the Senior Sister in particular, who was presenting the records to us as though they were accurate. It immediately caused us to distrust not only what we were being told at the meeting but everything else we had been told – if they were willing to lie about his observations, what else would they be willing to lie about? How could we trust the story (or stories) we were given about how [R/O] David sustained his injuries?

64. My family member told the Senior Sister that the records were false. I do not recall her being outraged, in fact, she did not really acknowledge it or say anything substantive at all. It was a stonewall response from memory – akin to a shrug and an, 'Oh, that's strange' type of reaction.

65. I recall Evelyn got upset during that meeting, telling the Senior Sister that we still did not understand what had happened. She said to the Senior Sister, *"He came to you, talking, and now he can't talk"*. She was crying, but again, I do not remember any sort of outrage by the Senior Sister about how shocking this all was, and Sister [I/S] did not contribute anything during the meeting at all, I recall her simply observing, impassively.

66. We left the meeting feeling disappointed and with more questions than when we arrived.

67. Two weeks later Evelyn received a letter from the Senior Sister, dated 22 January 2014. I have included this letter in my list at APPENDIX 1. I have also broken down the contents of the letter below, with my commentary thoughts. Please note that the emphasis/bolding of words has been added by me as they are the parts of the letter I am commenting on:

a. LETTER: *"Thank you for agreeing to meet with myself on Thursday 16th January 2014 to discuss* ***the very understandable concerns*** *you and your family have in relation to your husband, Mr David Cannon's recent stay at Meadowview Ward.*

I am very sorry that the ***Mr Cannon's physical health condition deteriorated to the point that he required emergency admission to Basildon Hospital so shortly after his admission to our ward*** *and I hope that he will soon be showing signs of improvement so that he can return home which I know is what his family really want to happen."*

MY COMMENT: The acknowledgement that **David's** health rapidly deteriorated whilst under their care, is to me, an admission that Meadowview was totally unfit for purpose. Before he was sectioned, **David** was a 77-year-old man who was in many ways independent; he was able to go the shops, take walks and even use public transport by himself. Within six days of his admission to Meadowview, he was hospitalised, unable to communicate verbally, visibly traumatised and covered in suspicious bruises, and the fact that we have never been given a reasonable or consistent explanation as to how or why that occurred, coupled with the lack of any serious investigation, highlights their incompetence and complete lack of integrity.

b. LETTER: "*During the discussion between yourself,* **and two other members of your family** **[R/O]** *and Deputy Sister* **[I/S]** *and myself,* ***we tried to answer all of your questions as fully and honestly as we could*** *from the information we had about the time Mr David Cannon spent on our ward and the circumstances which led to his transfer by emergency ambulance to the A&E department at Basildon General Hospital."*

MY COMMENT: I am afraid, we did not feel our questions were answered fully and/or honestly at all, in fact **the Senior Sister** was clear that she could not answer most of our questions because she had not been there and was not involved in **David's** care. The questions

that *were* answered were also not answered "honestly" given we were presented with observation records that were falsified. I also find it odd that the Senior Sister chose to attend that meeting without having done a shred of work to obtain accounts from staff about what happened to David. I question what use it was for her to attend, as opposed to a member of staff who was actually involved in David's care, and why she was so unprepared to address our concerns?

c. LETTER: *"Unfortunately, as I explained, we could not provide you with a specific cause for this sudden deterioration* ***as we have not been kept fully informed of all the clinical diagnosis being made by Basildon Hospital since his arrival there but were happy to share with you all the information relating to his time on Meadowview Ward****. I understand from what you all told me that the staff at Basildon Hospital are regularly updating you all."*

MY COMMENT: The excuse here is shameful. It purports to justify the lack of effort or any curiosity on her part to find out what caused [R/O] David's need for hospitalisation, by shifting blame elsewhere. What does his condition in Basildon Hospital have to do with whatever occurred at Meadowview that brought him to hospital in the first place? The *"specific cause for [his] sudden deterioration"* could have been addressed by Meadowview but never was.

It is also untrue that they were *"happy to share all information"* with us regarding David's stay, when, again, all that was shared with us at that meeting – and only orally – were falsified observation records. We have never received evidence or information regarding any investigation concerning his stay. I trust that now that this inquiry is investigating systemic issues regarding mental health care in Essex, for which SEPT is a key feature, the Trust will be forthcoming finally in sharing all records held regarding David's care and treatment, and address all my concerns about the questionable activities on Meadowview ward that caused his injuries, deterioration and ultimately led to his death.

d. LETTER: "*At the end of our meeting you gave me a letter detailing the concerns you wished to raise which you asked that I put on file in Mr Cannon's notes,* ***even though you felt that we had covered all the points during our meeting and that you were all satisfied that we had given you all the information we could relating to each of the issues****".*

MY COMMENT: The letter she refers to here may be **Evelyn's** letter of complaint, but I am unclear whether it was the one I have exhibited with this statement or another one – I simply don't remember. But it was an obvious falsehood to claim that we felt all points had been covered by them at that meeting, and it was dishonest to state that we were in any way satisfied that we had been given all the information that was available. We still have many unanswered questions about what occurred. Most notably, during the course of the meeting we had made explicitly clear to **the Senior Sister** that the observation notes she had just read to us were at least partially fabricated. Whether we explicitly asked her to investigate this or not – which, to be clear, I simply do not remember – it would obviously have been incumbent upon her as an agent of the Trust to report back and investigate such a very serious matter. It appears this never happened.

e. LETTER: "*Since our meeting* ***I have shared that letter with*** **[I/S]**, ***Consultant Psychiatrist, and*** **[I/S]** ***our Matron, and who have also looked at Mr Cannon's records to review his care and see if there are any lessons that the team at Meadowview could learn from this****."*

MY COMMENT: We are told here that a review of **David**'s care was conducted to ascertain what lessons can be learnt and yet there are no lessons outlined in the letter. Does that mean not a single lesson was identified in **David**'s case, despite the fact that he was taken to hospital on an emergency basis after suffering extensive bruising? And if there *were* lessons identified, why were we not given this information? There was no follow up with us on this, as we were never contacted again by the Trust, so we have no idea if any changes were in fact implemented following this incident. Again, it is a

substandard reply and feels very much like lip service and an attempt to cover their tracks.

f. LETTER: *"I have also investigated the information you gave me about one of the members of staff who was providing a one to one special to Mr Cannon at Basildon General Hospital, whose attitude towards yourself and Mr Cannon's care was not as helpful as it should be. By a process of elimination I am pleased to be able to inform you that the person concerned was an agency nurse and as a result of our conversation I have informed the agency* ***that I would not be prepared to have her work at Meadowview Ward again as I am not happy about her attitude, which I do not feel reflects the ethos of care promoted by Meadowview Ward towards our patients and their carers****".*

MY COMMENT: As far as I am aware, this is the only affirmative action that was taken by Meadowview in relation to **Evelyn**'s complaint. The nurse identified is the nurse who attended Basildon hospital on the first day of **David**'s admission and questioned my **family member** aggressively about her relationship to **David** and why she was at the hospital. I find it curious that this person was told not to return because their attitude did not *"reflect the ethos of care promoted by Meadowview towards…patients and their carers"* – and yet nobody was held responsible for falsifying **David**'s observations and no explanation has been provided for the conflicting accounts regarding **David**'s injuries. I question why the *"ethos of care"* did not apply to those issues, which were the ones most important to **Evelyn's** complaint and should have been important to **the Senior Sister** to investigate. In my opinion, the failure to do any proper examination of these events is telling of their practices and I would argue shows a clear lack of care for their supposed *"ethos"*.

68. Upon receipt of the letter, **Evelyn** asked me whether I understood it to be an accurate description of the way we had left the meeting and I reassured her it was not. The next time I saw **Evelyn**; she gave me the letter and asked me to look after it. It has remained in my possession ever since.

69. We considered escalating the complaint after receipt of this letter as we felt we could demonstrate unequivocally that his medical records had been fabricated. However, circumstances overtook. Towards the end of January/beginning of February, the hospital made clear to my family that David was not going to recover and suggested they see if he could be moved to St Luke's Hospice in Basildon. I recall that this was investigated but that the hospice had no capacity at the time, so he remained in Basildon Hospital on palliative care.

70. The idea of pushing forward with a complaint at that point became less important than being in the hospital every day, keeping an eye on him. Then when it became clear David was dying, any thoughts of a complaint faded away. We received no form of apology after he passed away. I recall feeling very angry about what had happened to David and feeling that I owed it to him to investigate what had happened. But I also recall that two or three days before David died, when we knew his death was imminent, I arrived at work and bumped into a trusted friend and colleague, I told him what was going on and that I would likely have to take compassionate leave in the coming days, and after listening to what had happened, he told me I should carefully consider whether to take on the NHS. He warned me that the NHS would likely fight us at every step, would seek to cover up any mistakes or misconduct, the battle would probably go on for years and even if we eventually won, all we would get was an apology, which wouldn't bring David back, and getting that apology would have consumed an enormous amount of time and effort and caused substantial stress and distress. As a result, my family and I did not go forward with the complaint.

Transfer to Palliative care

71. As David's condition continued to deteriorate in hospital, it became increasingly clear that he was approaching the end of his life.

72. At one stage prior to his passing, a family member realised his fluid drips had been withdrawn and was extremely angry and upset about it. She realised the hospital had effectively put him on the Liverpool Pathway, which the NHS was very specifically not supposed to do anymore. She demanded his fluid drips be put back on again. Whether they thought he was going to die or not, she did not want him being left to starve.

73. On 5 February 2014, he had been moved to a private room as the medical team believed he had only a short time left. Within 24 hours of that transfer, he died.

74. I wasn't there for that final moment, I did not really want to see David like that, but he was on constant watch, so Evelyn and other family members [R/O] were all there at the end.

75. My family members came home late that night, on 6 February 2014, and told me and another family member [R/O] that he had passed away.

After David's Death

76. As mentioned, I was not David's primary support at the time of his passing, so my knowledge of the Trust's actions after his death is limited, and as Evelyn has passed away, I do not have documentation or her assistance to help jog my memory.

77. That being said, I do not believe any support was offered by the Trust to members of my family after David's death. There is no evidence of that, and I am sure Evelyn would have kept such documents had she been given any.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

78. There was also no investigation, no examination of the events and no feedback or follow up with members of my family regarding his care or treatment, after his passing.

79. We were so distraught by David's death, and so disillusioned with the NHS at that time, that we decided against any formal complaint or legal action, as above, we felt the NHS would do nothing and we would spend years fighting an uphill battle.

80. Due to the death being labelled one of natural causes, there was also no inquest and I wholeheartedly regret that now. If I had been thinking about it more intently, I would have definitely requested one, but by the time David died, his injuries had subsided and so neither we nor anyone external made the connection that those injuries could have been linked to the cause of his death.

81. Irregardless, there is no doubt in *my* mind today that the cause of David's death was because of and/or triggered by those injuries. From that moment on, he lost his ability to talk, speak, eat or have any significant control of his bodily

functions. There is no question in my mind, or that of my family, that the mystery incident which caused those injuries catastrophically damaged him and was a direct causal factor in his death.

My views

82. In summary, I have the following concerns to raise about his care and treatment by SEPT:

    a. As a family we first and foremost believe that **David** was unnecessarily sectioned. We believe that the assessment he was put under at his home on 30 December 2013 was far too basic and that his symptoms at that time did not justify a need for an immediate involuntary detention under section;

    b. We believe our concerns regarding the decision to section him were also totally ignored;

    c. We believe Meadowview ward was a completely unsuitable place for him given that his condition was at a far less severe stage than most of the patients we observed on the ward;

    d. Once he was sectioned, we believe he was not taken care of as he should have been and that he was detained under false pretences;

    e. We believe that at some point between the evening of 4 January 2014 and the morning of 5 January 2014, he suffered deeply concerning physical injuries at the hands of staff on the ward. It is our firm belief that he was either neglected or unduly physically attacked in some way which caused him to sustain significant bruises. We do not believe the conflicting explanations that were provided, of him falling out of a bed or from a chair or possibly having a seizure;

    f. Regardless, there has never been a consistent explanation as to how he sustained his injuries nor any documentation of the same, so it is difficult to believe the narratives in any event;

    g. It is undeniable that the severe decline in both **David**'s physical health and his mental health whilst he was an inpatient on Meadowview ward was unquestionably rapid. In our view, this decline was not something that happened to him, rather it was something that was done to him;

    h. It is our belief that his injuries caused irreparable damage to his health and directly contributed to his death;

i. David's observational records were falsified and no explanation or accountability has been given for this, even though it was flagged to [I/S] the Senior Sister during the meeting I attended;

j. We consider it appalling that no real investigation, capable of finding truth and/or holding staff responsible, has been conducted to date, into either the incident which caused the injuries or the fabrication of the records, despite the seriousness of both events;

k. Finally, we as a family believe the manner in which David passed away was entirely preventable and would not have happened if he was not sectioned to Meadowview at all.

83. I am asking for these concerns to be addressed, and I reserve the right to submit additional thoughts following the receipt of evidence.

My Questions

84. I welcome an investigation by this Inquiry into David's death and into the culture and conditions at Meadowview at that time. Important questions for me would include:

a. Was David the only person to die or suffer serious injury under disturbing, violent or unexplained circumstances after being detained/treated at Meadowview?

b. Did any other patients or families file complaints about physical abuse or improper behaviour at the hands of Meadowview staff?

c. Did Meadowview ever act on the revelation that David's observation records had been fabricated? If yes, why were we as a family not informed? And if no, why not?

d. Was any action ever taken against the person or persons who fabricated the records?

e. Was any investigation launched into whether the culprit or culprits had fabricated any other patients' records?

f. Was any investigation ever conducted into why the records had been fabricated? Was there a staffing issue, which meant staff could not keep up with the demanding schedule of patient observations? If so, was this corrected?

g. Did any staff ever prepare any statements or documents explaining how David incurred his injuries? Or did the NHS simply never investigate

how an elderly patient in its care came to be covered, head to foot, in severe bruises?

h. Again, if there was some investigation into how David suffered his fatal injuries, why were we not informed, and what was the outcome? And if there was no investigation, why is that?

Recommendations for change

85. I submit the following recommendations for the Chair's consideration:

a. **Appropriate risk assessing** – I am concerned that in David 's case, the assessment of risk that determined him necessary for section on 30 January 2014 was wholly inappropriate. So my recommendation is for a clear assurance process that ensures assessments being conducted are in accordance with clinical practice and need, and, where management in the community might be the more suitable option, there should be a process taken that involves families so that they can feel confident that this alternative and less drastic measure has been duly and properly considered before being ruled out;

b. **Assistive technology in older adult patient facilities –** As far as assistive technology is concerned, I do believe there may be benefit in having fall sensor alarms on all older adult frailty units, particularly given these patients are usually already at high risk of falling. However, I would advocate that any such alarms must not be used to replace the active support given by staff, it should simply be used as a protective measure to alert staff to a specific danger occurring;

c. **Post-incident investigations** – Perhaps worse than seeing David bruised from head-to-toe and shaking in fear in a hospital bed, was not knowing what on earth happened to him that caused him to be that way. It is abhorrent that the Trust got away with doing no work to get to the truth of the matter, and in the face of glaring inconsistencies and an attempt to fabricate records after the fact. Where an inpatient sustains an injury or there are reasonable grounds for suspicion of foul play, harm or abuse, there has to always be a thorough investigation that is ultimately signed off/overseen by a senior person to ensure the process is carried out comprehensively. Whether a complaint is submitted or not, injuries and/or suspected harm/abuse are always incredibly serious and should automatically trigger a formal examination of the events, not least so that the potential immediate risk to other patients can be properly mitigated

against. Families/complainants should thereafter be kept informed of the progress of the investigation, accounts of staff members involved should always be taken and there should always be an avenue for families to request the underlying evidence that formed part of the investigation once its complete. Complaint procedures must also be simple and easily accessible for families and an effort should be made to explain to families what their rights are to appeal a complaint;

d. **Pattern of neglect with elder patients** - We are seeing through this inquiry process that there may be a pattern emerging in relation to the poor care of elderly patients in Essex inpatient facilities. I am concerned about this trend and trust the inquiry is taking notice. Unwitnessed falls, failure to conduct timely observations, falsifying observations, conducting inappropriate risk assessments and serious injuries being sustained as a result, are all repeat features that we are seeing. There has also been concerns raised about staff attitudes, lack of training, staff shortages and dishonesty issues. It is important that with regard to David and so many other families who have lost elderly loved ones under state care, this Inquiry make specific mention of the vulnerabilities older adult patients face, who are often at a heightened risk of injury on wards. The concerns that impact such patients are notably different to other kinds of mental health wards where accidental physical injuries (particularly from old age, etc) may not be so prominent. There must be an examination as to repeat patterns of neglect by staff, and concrete recommendations must be made so that these repeat issues are no longer a risk.

List of documents for the inquiry to obtain

86. At APPENDIX 1, I have outlined the limited documents I have in my possession that I have used to formulate this rule 9 statement. You will see that it is hardly anything and certainly does not include any records pertaining to David 's admission, care and treatment at Meadowview ward or his transfer and admission to Basildon Hospital before he died. I have nothing by way of evidence from SEPT aside from the single letter that is dated 22 January 2014 that was sent to Evelyn . The following is a full list of records that I now require from SEPT:

    a. All records held by Meadowview regarding David 's care and treatment (between 30 December 2013 – 5 January 2014), including but not limited to:

i. Any records held by Meadowview regarding the decision to section David on 30 December 2013;
ii. All written correspondence between Meadow ward staff members and independent medical professionals regarding David's care;
iii. All minutes of meetings between Meadowview ward staff members and independent medical professionals regarding David's care;
iv. All care plans and risk assessments;
v. All psychiatric assessments, ward round reviews and doctors reports;
vi. All documents regarding any changes in his medication;
vii. All written communication to and from the Senior Sister, Deputy Sister , Consultant Psychiatrist and Matron regarding David;
viii. The documents relating to the decision not to have the unnamed agency nurse back on Meadowview ward;
ix. Any and all witness statements or accounts taken from staff in relation to this case;
x. The complete observation records, with a history of edits/metadata showing when they were last edited
xi. Any and all photographs/footage available
xii. Any notes or minutes of the meeting between my family and the Senior Sister [I/S]
xiii. Any emails or letters sent to anybody by the Senior Sister in the days and weeks after that meeting, which referenced David's case
xiv. Any emails, letters or other documents detailing any suggestion or discussion of investigating any aspect of David's care, plus the progression of those discussions and any resulting investigation reports

b. All documents considered as part of Evelyn's complaint of 14 January 2014;
c. Complete set of Basildon hospital records (between 5 January 2014 and his discharge)
d. the following policies:
    i. Slips, Trips and Falls Clinical Guidelines
    ii. Falls Safe and Supportive Observation Guidelines

iii. Engagement and Supportive Observation Procedure

e. The national guidance in place in 2020 regarding the use of Assistive Technology in Older People Inpatient services.

Statement of Truth

I believe the content of this statement to be true.

SIGNED [R/O] .....

Y15

Dated 01.10.2025 .....

RULE 9 WITNESS STATEMENT OF Y15 PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

APPENDIX 1 – LIST OF DOCUMENTS WHICH I HAVE

Document	Date
Letter of complaint by Evelyn Cannon	16.01.2014
Letter from family of David Cannon	23.10.2024
Photographs of David Cannon's injuries	-
Letter of response by the Senior Sister	22.01.2014