Statement of Core Participants
Name: Alex Guille and Paul Guille
Exhibits: TBD
Date: 3 June 2025

THE LAMPARD INQUIRY

STATEMENT OF ALEXANDER GUILLE AND PAUL GUILLE

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1. Preamble

1.1. We make this statement in response to a Rule 9 request received on 3 March 2025 in relation to our sister Bethany Lilley (whom we called Beth) who died on 16 January 2019 when she was an inpatient at Thorpe Ward, Basildon Mental Health Unit.

1.2. Alex Guille: I am a teacher, and currently live in Colchester.

1.3. Paul Guille: I work as an education officer, currently based in Norwich.

1.4. Whilst this statement is based on our knowledge and beliefs we have considered documents to refresh our memories and have consulted with our family members to ensure that that the statement is accurate and sets out the broad areas of concern we have as a family collectively.

1.5. Losing Beth has been devastating for our family. We are participating in the Lampard Inquiry in the expectation and hope that it will make foundational changes to the mental health services in Essex and nationally such that no other patient or family has the experiences that Beth and we went through.

2. Approach to Documents

2.1. We have set out below an overview of Beth's admissions to provide a factual framework for this statement. We should be clear that some information is from records and that we were not always aware of the issues at the time; one of the key concerns for our family has been lack of communication from

clinical staff about Beth, for example we were only told after she died about a serious attempt on her life in the days preceding her death. It is therefore true that we have discovered information that we were not aware of contemporaneously throughout the investigations into her treatment and death. This has been emotionally challenging and very distressing for our family. Many of the details we refer to below are from her medical records and are provided to assist the Inquiry have a clear factual overview but we were not aware of all of the details at the time.

3. Structure of the Statement

3.1. The statement is structured as follows:

Part 1 – Facts

- **Beth's Background** [paras 4.0 -4.9]
- Events [paras 5.0-5.109]
- Adolescence [paras 5.1-5.3]
- 2016 [paras 5.4-5.10]
- 2017 [paras 5.11-5.13]
- Early 2018 [paras 5.14-5.41]
- Peter Bruff Unit Nov 13-15 2018 [paras 5.42-5.43]
- Thorpe Ward Nov 15-22 2018 [paras 5.44 – 5.49]
- Thrope Ward Nov 24-26 2018 [paras 5.50-5.59]
- Peter Bruff Unit Dec 10-18 2018 [paras 5.60-5.66]
- Peter Bruff Unit Dec 30-3 Jan 2019 [paras 5.67-5.72]
- DATIX [paras 5.73- 5.82]
- Discharge [paras 5.83-5.85]
- Community 5-9 Jan 2019 [paras 5.86-5.88]
- Peter Bruff Unit 9 Jan -15 Jan 2019 [paras 5.89-5.101]
- Transfer to Thorpe Ward 15-16 Jan [paras 5.98-5.113]

Part 2 – Rule 9 questions and answers

- Diagnosis [para 7.0 – 7.8]
- Assessment [paras 8.0-8.10]
- Admission [paras 9.0-9.4]
- Ward Environment [paras 10.0 -10.11]
- Staffing [paras 11-11.5]
- Care Management and Plans [paras 12.0-12.9]
- Treatment [paras 13.0-13.13]
- Safety [paras 14.0-14.14]
- Leave Absconsion and AWOL patients [paras 15.0-15.6]
- Transfer [paras 16.0-16.2]
- Discharge/Continuity of Care [paras 17.0-17.5]
- Family Engagement [paras 18.0-18.4]
- Concerns, Complaints, Quality, Timeliness, Openness [paras 19.0-19.8]
- Quality of Investigations [paras 20.0 -20.23]
- Legal proceedings [paras 21.0-21.11]

Part 3 – Our views

- Recommendations.[paras 22.0-22.13]

Part 1: Facts

4. Bethany Lilley: Background

4.1. Beth was born on 12 September 1990 at Colchester General hospital. She was the youngest of a set of twins and the youngest of six siblings from Dr John Guille (now deceased) and Mrs Julia Guille. Our parents separated when Beth was 12 years old.

4.2. Beth was born in a breech position; it is not clear whether there was any impact of this period of oxygen starvation on Beth. Although it did not affect her physical development, the family have always felt it may have impacted her emotional development.

4.3. As a child, Beth was energetic and kind. At 16 years old Beth was diagnosed with and treated for ADHD. She was prescribed Ritalin but did not like the side effects and stopped taking it, and as far as we are aware, this was never followed up on, nor was any alternative trialled. She had to change schools from Tendring Technology College, the senior school attended by her brothers, and was moved to Bishop's Park, a school in Clacton. Shen then moved to Sr Mary's school in Colchester. After her diagnosis, she dropped down an academic year and left St Mary's with five GCSEs.

4.4. Beth was a very caring individual. She was fiercely loyal to her friends and would be there no matter what day or night to provide emotional or practical support. Beth had six nieces and nephews who were aged between 2 to 10 when she died. She absolutely adored them and requested photos of them while she was an inpatient as she recognised that thinking of them helped her through her days.

4.5. She had one close friend, who grew up in care and then had a child, and so didn't really have any parenting expertise, as it were. So Beth used to help out a lot and basically co-parented with her friend, essentially it seemed like at times. That's just a mark of how much she did care and how much she had time for all kinds of people. There was genuinely not a judgemental bone in her body. She saw every single person at face value too, sometimes to a fault in a way, but a really admirable quality.

4.6. She loved music as well. Her favourite artist was Eminem and we used to hear that a lot coming through her bedroom walls and through the ceiling when she was living with our mum.

4.7. Beth worked at our father, Dr John Guille's GP surgery as a Health Care Assistant and phlebotomist from 2012. She was widely regarded as brilliant at her job, loved by her patients and the staff. Above all else, she wanted to be a mental health nurse. She managed a year of the training, but although she managed the placements well and got good marks for her placements,

she found the academic work difficult, because she'd missed a lot of her education. In 2014 she studied at Angela Ruskin University to become a qualified nurse with the intention to specialise in Mental Health but unfortunately, she did not pass the academic assignments. She was diagnosed with dyslexia around this time. In around September 2018 she then applied to study nursing at the Open University.

4.8. Beth had a series of abusive and traumatising relationships with older men from a young age. Her father John took a restraining order out against one of the men. She suffered domestic violence in these relationships.

4.9. In 2015 Beth married her childhood sweetheart, lived in the family home then moved to own place in Colchester with her husband, until they separated during an intense period of mental illness.

5. Events

5.1. There was no single event that we can point to which led to a deterioration in Beth's mental well-being. She became quite ill about three years before she died following some involvement with the mental health services as a teenager and then had no contact with mental health services for quite a long time. It was about two or three years before she died that she became very unwell and self-harmed, and started using quite a lot of cocaine and alcohol.

Adolescence

5.2. Beth had contact with Children and Adult Mental Health Services (CAMHS) when she was a teenager. As set out above she was diagnosed and treated for ADHD when she was about 16 years old. An independent report commissioned by the Thurrock Clinic Commissioning Group refers to Beth admitting to taking an overdose when she was 15 years old and states that she was referred to mental health services by her GP. [Independent Investigation into the Care and Treatment Provided to Ms A by the Essex

Partnership University NHS Foundation Trust by Duncan and Johnstone **dated March 2020, hereafter referred to as 'independent report']**.

5.3. From the records available to us it is reported that when Beth was 25 years old she attended A&E twice due to overdoses on 16 December 2015, 18 December 2015 and once due to lacerations on her left arm on 28 December 2015 Initially she was either kept in overnight on the A&E ward for observation or was discharged and referred to Crisis.

2016

5.4. From the GP records, we understand that Beth attended A&E 23 times in 2016 for acts of self-harm from overdoses to deliberate self-harm with lacerations. Initially she was either kept in overnight on the A&E ward for observation or was discharged and referred to the Crisis team. [Colchester Hospital List of A & E Attendances, December 2015 through January 2019]

5.5. Between 17 January 2016 and 3 February 2016 she was admitted as an informal patient on Ardleigh Ward at the Lakes. This was her first inpatient admission. During this admission she self-harmed on the ward by burning her wrist **[I/S]** She was diagnosed in the course of this admission, for the first time as far as we can see, with Emotionally Unstable Personality Disorder (**'EUPD'**) on around 18 January 2016. Dr **[I/S]** who later assessed Beth on 9 May 2016, seems to accept this diagnosis, increasing her prescription of Duloxetine (an anti-anxiety medicine) and Pregabalin **She** says the **diagnosis was arrived at by the "Inpatient Consultant Psychiatrist" from this admission but it is not clear from the entry in her** medical notes who the clinician who arrived at this diagnosis was or how they arrived at this diagnosis. **The entry in her case note refers to a "Dr [I/S]."** [Medical Records, Discharge Summary 3 February 2016, Case Notes 17 January 2016 to 3 February 2016]

5.6. After being discharged she attended the Haven Project . She was also under the care of the Home Treatment Team (**'HTT'**), **sometimes also referred to as**

the Home First Team, initially following her discharge and then discharged into the care of Specialist Mental Health Team (**'SMHT'**) on 22 February 2016.

5.7. We address this further below but a key concern for our family is also the community care Beth received. When she was receiving community care it appeared to be unstructured. Beth said that her treating teams in the community would never have a set time to meet her and what they would offer her in terms of community care and treatment seemed quite random.

5.8. On 13 May 2016 Beth self-harmed by taking an overdose. She was detained under section 2 of the Mental Health Act. She was admitted again to the Ardleigh Ward, at the Lakes. This was her second admission. She was diagnosed with depression and EUPD and **assessed as "high moderate risk** of suicide and self-harm; **low risk of vulnerability and low risk of neglect"** On 8 June 2016 she was detained under section 3. She was then discharged on 25 July 2016. Following discharge, Beth attended A&E five times due to self-harm. [Colchester Hospital List of A & E Attendances, December 2015 through January 2019]

5.9. On 28 August 2016 Beth was admitted as an informal patient to the Ardleigh Ward. She attended A&E 4 times due to self-harm and overdoses. On 21 October 2016 she was detained under section 3 of the MHA; on 31 October 2016 she was transferred to the Peter Bruff Unit at the Kings Wood Centre under section 3. She was discharged on 12 December 2016. During this detention, we understand that Beth began burning herself **[I/S]** and continually cut herself using blades whilst on ward. She had 7 A&E visits for self-harm between September and December.

5.10. As you can see from the above there was a pattern where Beth would be admitted, discharged and then be bounced back multiple times without, it appeared to us, any apparent oversight of her care or clear treatment or care planning.

2017

5.11. On 24 January 2017, Beth had an assessment with a consultant psychologist Dr [I/S] where she disclosed an intention to take her life by overdose on paracetamol or heroin and disclosed the existence of a suicide pact with another service user. She had a further five sessions with Dr [I/S] between 31 January 2017 and 10 March 2017. We cannot comment on how useful Beth found these sessions, as she was either flippant or scathing about how useful the care she received in the community was. [Statement of [I/S] [I/S] dated 18 November 2019]

5.12. On 20 March 2017 she was informally admitted to Chelmer Ward in Derwent Centre following an overdose. She was transferred to the Peter Bruff Ward on 30 March 2017 where we understand she **was managed under "Level 2"** observations. On 31 March she was discharged. We are not aware of the reasons as to why she was admitted and then discharged so quickly but it reflects a pattern of a revolving door of admission/discharge/community which appeared to do little to help Beth. [Medical Records, Case Notes 20 March 2017 to 31 March 2017, Discharge Summary 20 March 2017]

5.13. Except for a short informal admission of 2 days from 26 June 2017 from which she self-discharged, from June to December 2017 she was managed in the community by the HTT and the SMHT. she also continued with her therapy sessions. This was a period of relatively stability. We understand she was engaging in cocaine use at the time and that some consideration was given to sending Beth to a specialist unit but it was thought that she was not ready to cooperate. She was eventually discharged from the SMHT and back to the outpatient clinic.

2018

5.14. In 2018 Beth had a long period of admission of about 8 months to Ardleigh Ward on the Lakes. Our impression as a family was that this long period of **admission did not improve Beth's mental health. It felt like to us that** that long stay was detrimental to her; she was never the same after being in the Lakes. It felt to us that there were two options hospital or home and that she had

almost become institutionalised. We all visited Beth as much as we could when she was an inpatient in different facilities and we address below our views on the ward environments, staffing and treatment.

5.15. On 15 January 2018 Beth attended Colchester General Hospital following a serious overdose attempt **[I/S]** On 19 January 2018 she was detained under section 2 of the MHA when she disclosed an intention to take her own life. On 20 January 2018 she was transferred to the Priory hospital in Southampton under section 2. On 22 January 2018 she was transferred whilst still on section 2 to the Ardleigh Ward at the Lakes. On 9 February 2018 a Mental Health Tribunal upheld her detention. On 15 February she was detained under section 3. A further Mental Health Tribunal upheld her detention on 17 April 2018. On 30 July 2018 section 3 was rescinded and she remained an informal patient. [Medical Records, Case Notes 15 January 2018 to 13 August 2018]

5.16. On 13 August 2018 Beth was discharged.

5.17. During this eight-month inpatient admission, there was an ongoing issue with Beth allegedly using her periods of leave to obtain and smuggle cocaine onto the ward, and incidents where she was purportedly supplied the drug to other inpatient users. She also repeatedly tried to ligature, and self-harmed by cutting and by **attempting to** self-suffocate. She was admitted to A & E on five different occasions during this time.

5.18. About five months into Beth's **inpatient stay at the Lakes our** father Dr John Guille wrote to the Lakes raising concerns about the lack of communication from the ward staff, her continual self-harming even whilst on the ward, her use of illegal substances on the ward and that she was being bullied by another patient. [Letter from Dr John Guille to the Lakes, undated]

5.19. On 30 July 2018 her s3 MHA was rescinded and the reports say Beth was pleased by this. However, the very next day on 1 August 2018 according to her medical records **she called staff and said she had "done something" and** staff attended to find four significant wounds to her arm, requiring an admission to the A & E. Another serious self-harm attempt followed on the 6 August 2018, necessitating another admission to the A & E. Nonetheless her observations were reduced. On 12 August 2018 she apparently overheard in **the garden saying she would kill herself once discharged into her mother's** care. On 13 August 2018 she was nonetheless assessed fit for discharge and discharged into **our mother Julia's** care. [see Medical records, discharge documents dated 3 February 2016- 3 January 2019]

5.20. The discharge documents list her consultant psychiatrist as Dr **[I/S]** **[I/S]**, however, the discharge document is signed by a trainee Dr **[I/S]** Dr **[I/S]** gave evidence in the inquest in relation to this entire inpatient admission and said in relation to this discharge "*from what I remember, B was discharged to her mother's house with the support of the HTT to begin with*" When asked in the inquest how she could be taken off the section and be discharged in the context of cocaine use Dr **[I/S]** emphasized that it was in contrast to how she had been when she was first an inpatient, where there was routine, daily self-harming incidents. Dr **[I/S]** considered this an example of positive risk taking, something the independent report did not agree with; we also find it a very questionable decision. [statement of Dr **[I/S]** dated 25 July 2021, Discharge Summary dated 13 August 2018] **[I/S]**, Beth's **allocated care coordinator did not** attend this meeting as the meeting time was changed at the last minute [statement of **[I/S]** dated 15 November 2019] and so did not input into the decision making.

5.21. It has been a concern for our family that there often appeared to be little safeguarding or thought given to where Beth was discharged to or how our mum, who had her own mental health vulnerabilities, could safeguard or look after her (see further below). No one ever spoke to our mum about how she would be able to manage Beth or if she needed any help in doing so and

indeed it is self-evident that she was not in a position to do so not least as EPUT did not provide all the relevant information.

5.22. She was discharged with the following medication: Duloxetine 120 mg, Procyclidine 5mg,Bisopropol 1.25 mg, Pregabalin 200 mg, Omeprazole 20 mg, Aripiprazole 5 mg, Ferrous Fumarate 210 mg, Zuclopenthixol Decanoate 300mg, Zolpidem 10 mg and Clonazepam 1-2 mg.

5.23. It was at some point during her long admission to the Ardleigh Ward that we believe that Beth used her mobile to apply for several pay day loans, which she could not afford to repay. Beth told us that she was coerced into making these applications by another inpatient. During the course of this inpatient stay our father assisted her to attend Tendring Citizens Advice Bureau for help with these debts. Unfortunately, due to the lack of capacity at the Citizens Advice Bureau, it took many months to put a Debt Relief Order in place for these debts, which was eventually started in November 2018. During this time the calls, texts, and emails demanding repayments became more frequent and more aggressive, adding to the stress and difficulties Beth faced.

August 2018

5.24. **Following her discharge and move into our mother's home, our sister was** managed by the HTT who visited her once a day from 14th to the 23rd of August. The HTT staff reported that she continued to experience thoughts of suicide and engage in cocaine use. She was told to attend an assessment with Open Road, a charity which provides a Drug and Alcohol service.

5.25. As we referred to earlier. Beth found community care to be unstructured. We are aware that Open Road generally does a good job in the community. In fact our father often worked at the clinic to support those living with drug addiction. However, as you will see from the below, the contact with Open Road was limited. This is a good example of Beth being referred to a service with seemingly no follow up or communication with other services as far as we can tell.

5.26. During this time under the care of the HTT, on 20th August 2018 Beth self-harmed by cutting her arms and had to go Colchester General A&E at about 11 pm at night. She needed stitches.

5.27. The HTT continued to see her following her discharge until on about 29th August 2018, where they handed her over the Specialist Mental Health Team. Her care coordinator on the SMHT was still [I/S], a specialist mental health nurse who was assigned Beth from about 30 January 2018 to January 2019. She was meant to see Beth on a fortnightly basis when not under the care of HTT or an inpatient. That same day, Beth took an overdose [I/S] [I/S] and attended A & E. Her CC carried out an emergency assessment and increased her medication script to daily. [Statement of [I/S] [I/S] dated 15 November 2019]

5.28. On 4th September 2018 Beth had her first appointment with Open Road for a "comprehensive assessment". Following this, Beth continued to attend further appointments with Open Road, the last of which took place on 7th January 2019. [Open Road Treatment Services Report dated 12 September 2019]

5.29. On 10th September 2018 she had a post discharge appointment relating to her eight month stay at the Lakes with a psychologist who worked with her on Ardleigh Ward we now known to be Dr [I/S]. Dr [I/S] said that Beth disclosed during this appointment that she was engaging in sex work, and that she was being pressured into this by a man, and that she was afraid of this man. She also disclosed that she had concerns about returning to our mother's home as a result of this. As we are reviewing medical records we are not able to comment on whether this happened, although it is written in the records that Beth made this disclosure. Dr [I/S] evidence to the inquest was that she recommended she engage with the police and suggested women's refuges and made a note to follow up with [I/S], her care coordinator. However, as far as we are aware, despite these points of action being noted down in the records, this did not happen. We would note

that our sister was vulnerable to sexual exploitation and that she was often treated badly by men including one of her former partners that our father took a restraining order out in relation to. The harm she suffered as a consequence of sexual and physical violence from men plainly had an impact on her in many ways. [First Statement of Dr [I/S] dated 19 June 2019, Second Statement of Dr [I/S] dated 23 October 2019]

5.30 [Her CC] **arranged a "care services package" with a private agency to** encourage her to strengthen her community ties. Beth was supported seven hours a week in the community during this period by the agency, called Reed Care Services Limited. The purpose of this service was to offer Beth additional support to collect medicine and ensure compliance with her medication regime, manage her finances and personal care and engage with activities in her local community. She was assessed on 13 September 2018 by [I/S] of Reed Care, who found Beth to be withdrawn and almost non-responsive, with little by way of facial expressions. She mentioned to [I/S] that our mother also suffered from mental health issues and disclosed that she did not see the point in getting up in the morning and being alive, and that she frequently overdosed. Following this, Beth had a few further meetings with Reed Care between 8 October 2018 and 14 January 2019. However in a report made to the inquest Reed Care confirmed that it was difficult to support her during this time because of the frequency of her inpatient admissions. In the inquest Reed Care were critical about the short-term nature of these admissions and the focus on treating physical symptoms such as cutting and overdosing as to focussing on addressing the underlying causes. We would broadly agree with these concerns – there never seemed to be a clear plan for therapeutic care and long term treatment leading to risk reduction it just seemed to be crisis management. [Reed Care services report by [I/S], Registered Manager, undated]

5.31. On 14th September 2018 Beth attended a case management appointment with Open Road. A cocaine misuse plan was put in place and a referral to

Action on Addiction made on 19 September 2018. On the same day however she attended A & E following having cut herself.

5.32. On about 27th September 2018 Beth was sexually assaulted following a meeting a man at a Premier Inn hotel in Weeley. She reported this to Essex police on around 14 November 2018 and this was investigated by one PC [I/S]

5.33. On 5th October 2018, Beth attended A & E following an overdose.

5.34. On 9th October 2018, Beth's CC contacted [I/S] of the Dual Diagnosis Team, to report that Beth was back in the community and was using a lot of cocaine [I/S] assigned her case to his colleague [I/S] [I/S] who would be able to visit her at our mother's home.

5.35. On 15th October 2018 Beth disclosed to Reed Care, who informed her CC, that she had been the victim of a financial scam, causing her to lose about £100 of her mother's money. She was tricked into buying vouchers when selling her wedding dress. This should have been a red flag that she was vulnerable and open to exploitation. We were not aware of this at the time and obviously would have intervened if we had been. We feel that this was a result of the lack of practical support our mum received in being asked to look after Beth. The following day, on 16th October Beth had to attend the A & E having cut her arms.

5.36. On 28th October 2018, our father Dr John Guille passed away following a stroke. It was sudden and unexpected. Our father's death was an enormous tragedy for all of us, but had a profound effect on Beth.

5.37. On 1st November she called the Crisis line and said she wished to cut her wrists with a razorblade as she wanted to "be with him". She then attended Colchester General A & E after taking an overdose [I/S]

5.38. On 2 November 2018 Beth had a medication review with Dr [I/S] along with her CC both of the SMHT at Reunion house in Clacton. The documents record that she had apparently wanted to reduce her Zuclopenthixol decanoate depot injection as she was not taking it, and agreed to taking Aripiprazole 5 mg in the morning and Procyclidine 5 mg twice a day, as well as agreed to consider Lamotrigine and reduce her Duloxetine. We can't comment on the appropriateness of this medication review and can't really see what the rationale for the changes. However her medication regime never seemed to help.

5.39. We have set out our concerns about the way Beth's medication regime was administered below, but we have since Beth's death become familiar with the NICE guidelines on managing EUPD (NICE Guidelines CG 78) which state that in some instances antipsychotics can be prescribed on a short-term basis to manage transient psychotic symptoms, but in Beth's case they were prescribed for years despite no mention of psychotic symptoms in her medical records. Furthermore the NICE guidelines explicitly state that mood stabilizers and antipsychotics should not be used for long or even medium term treatment unless there are clear co-morbidities. This is a major criticism raised in the independent report and we do not understand how Beth's clinicians simply accepted years of treatment of antipsychotics and mood stabilisers in light of the above guidance.

5.40. On 9th November 2018 Beth once again attended A&E due to taking an overdose. On the same day, 9th November 2018 Ms [I/S] from the Dual Diagnosis Team apparently tried to visit Beth when she was not at home.

5.41. She was discharged home on the 9th but then we understand went to the A & E again on 12th November 2018 having overdosed once again, after visiting our father in his chapel of rest.

Admission to Peter Bruff Unit 13-15 November 2018

5.42. The next day on 13th November 2018 our sister was admitted as an informal patient on the Peter Bruff Unit. [Medical Records, Case Notes 13 November 2018 through 22 November 2018]

5.43. However on 14th November 2018 she attempted to self-asphyxiate herself [I/S] while on the ward. She was reviewed by Dr [I/S] a Consultant Psychiatrist. Dr [I/S] noted that her mental health has deteriorated significantly and that she was displaying constant suicidal thoughts. She noted that she was on level 3 constant observations and was using cocaine in the community. Following assessment Dr [I/S] determined she was unable to keep herself safe outside of the ward environment and needed to be observed in an **environment where she "could not use cocaine"** She authorised her detention under section 3 MHA. We do not recall if we were told about this though our mum may have been. [Section 3 Application by Dr [I/S] dated 14 November 2018]

Thorpe Ward 15 November 2018- 22 November 2018

5.44. At around 10 at night on 15 November Beth was transferred to Thorpe Ward at the Basildon Hospital from the Peter Bruff Unit. From the documents, she remained on level 3 observations requiring constant watch. She was assessed as being as at high risk of suicide and self-harm.

5.45. According to one of her treating psychiatrists Dr [I/S] who gave evidence at the inquest, she was assessed at a multi-**disciplinary team meeting ('MDT')** on 16 November 2018. We were not aware of this at the time. Dr [I/S] says

that she told the team that seeing our father at rest was very distressing, and according to Dr [I/S], also spoke about her cocaine use. Dr [I/S] also says that on this occasion they contacted our mum Julia by telephone to feed into the MDT. She continued to be detained under section 3. Her medical notes confirm that she continued to be 'high risk' in relation to suicide. Following this, however, her observations were reduced to level 2. [Statement of Dr [I/S] dated 1 November 2019]

5.46. On 19 November 2018 her section 3 was rescinded. We have exhibited to this statement the "record of discharge" from section, which says that a family member was informed by nursing staff. [Record of Discharge from Section dated 19 November 2018] As far as we are aware, this was the last time she was detained under section, with all of her subsequent inpatient stays were "informal admissions". It is not clear from this record of discharge document or the case notes what the rationale behind the section 3 being rescinded is. In fact, Beth's case notes go straight from 17 November 2018 to after 23 November 2018. We can only rely therefore on the evidence of Dr [I/S]. Dr [I/S] says that given that there was no "formal thought disorder" and she had no active plans to kill herself – though she had a cut from banging her head on the wall – it was decided that her "Section 3" would be rescinded and that she remain as an informal patient. [Statement of Dr [I/S] dated 1 November 2019] However she remained high risk on her risk assessment. A plan was made to discharge her on 22 November. The EPUT Serious Investigation Report suggests that this was also done to permit Beth to go to our father's funeral. [Root Cause Analysis Investigation Report by EPUT dated 31 July 2021, amended 27 August 2021]

5.47. On 22 November, Beth was discharged as an informal patient from Thorpe Ward , supposedly with five days medication. She was prescribed Duloxetine 120mgs Procyclidine 5 mgs, twice daily, Bisoprolol 1.25mgs, once daily, Pregabalin 200mgs, twice daily, Omeprazole 20mgs, once daily, zuclopenthixol decanoate, 2 weekly. The Serious Investigation Report justifies this discharge on the basis she was "futuristic" in her approach and

seemed pleased with the plan. [Root Cause Analysis Report by EPUT dated 31 July 2021 updated 27 August 2021]

5.48. According to her case notes, Beth was in fact discharged without the medication she had been prescribed, and had to call the ward on 23 November to complain about this. [Medical Records, Case Notes 22 to 24 November 2018] She also said she had not been referred to the Home First team as had been discussed as part of her discharge plan. She reported that she had difficulty coping without her medication and that her GP would not prescribe her medication. She was advised to call the Crisis Line whilst staff could check and see what they could do. We note that the EPUT Serious Investigation Report does not record her leaving the ward without her medication. [Root Cause Analysis Report by EPUT dated 31 July 2021 updated 27Augus 2021]

5.49. We strongly disagreed with the decision to discharge her on this occasion. As we set out in the letter to the Coroner in the inquest, we felt that this was an unbelievable action, with the Mental Health Team showing little understanding or insight into the way that Beth was failing to cope with our father's death. Subsequently Beth was readmitted very quickly after the funeral. In the four months between John's death and Beth's death, she was admitted as an inpatient to Basildon at least four times.

Thorpe Ward 24 November 2018- 28 November 2018

5.50. Our father's funeral took place on 23 November 2018. Paul picked her up to attend the funeral and they drove together. Beth was not well. Beth was what we would describe as 'zombified'; she could be like this when she was on medication. She was slow and sluggish [I/S] from being so dosed up. This was one of the side effects of her medication and these became more pronounced in the months prior to her death. She also put on a lot of weight in those last few months. It was really shocking seeing the physical changes in her – in a rather short space of time, she changed from the youthful, bubbly,

energetic and defiant character that we grew up with to someone who was slow, sluggish and overweight. We do not understand how such dramatic physical changes did not seem to concern her treating clinicians or prompt a review of her medication.

5.51. The day after the funeral on 24 November 2018 Beth attended Colchester A&E saying she had suicidal thoughts. Following an assessment with A&E Liaison Nurse she was re-admitted as an informal patient to Thorpe Ward and placed on level 2 observations.

5.52. From her medical notes, she complained in the course of this assessment in **the nurse that she that** "*she was not happy when she was told that she was being discharged from Thorpe ward as she did not feel that she was ready for discharge. She states that she expressed her concerns and her continued suicidal ideation to staff on the ward but she feels that this was not taken seriously. She also states that she believed that following discharge from the ward she was transferred to Home First Team. Beth said that she felt further let down by services after being told that she had not be referred to HTT and that she felt generally unsupported. She acknowledged that she is still open to SMHT but said that she feels that she needs far more intense support than this at present.*" It is concerning to read this as it shows that Beth herself felt that she was not being taken seriously and that she wanted to get better but no one was helping her do so. The fact that she says she was unhappy with being discharged contradicts the statements of Dr **[I/S]**. [Medical Records, Case Notes 23-24 November 2018]

5.53. On 28th November 2018 she was discharged as informal inpatient from Thorpe Ward and referred to the Home Treatment Team. We have significant concerns about this decision to discharge, especially given with Beth herself said four days earlier. There appeared to` be no longitudinal assessment of **the impact of our father's death, Beth's** vulnerabilities, coping mechanisms and co-occurring conditions.

5.54. She was identified by her GP as a vulnerable adult in November 2018. Her **GP recorded**: "*She was a vulnerable adult on the system due to borderline personality disorder and several attempts of self-harming for which she had vigorous input from the Mental Health Team, Crisis Team, and Clinical Psychiatrist. She was also known to do substance mis-use, and quite a few times in the documentation completed at A&E she was abusing Cocaine. In view of her being high risk for self-harming and due to her multiple suicidal attempts in the past, we even issued her medications on a daily prescription to minimise the risk.*" **[Letter from GP to HM Coroner's Office dated 11** February 2020]

5.55. In December 2018 Beth was discharged from Dual Diagnosis Team back into the care of the SMHT. From their witness statements to the inquest, neither **[I/S]** the person in Dual Diagnosis team to whom Beth had been referred, nor **[I/S]** were informed about this or the justification for doing so. **[I/S]** said in his statement that he could only deduce the reasoning in the medical notes. His colleagues reasoning was initially that Beth would not be able to access alcohol when an inpatient in November 2018, and in December 2018 his colleague noted that Beth is at home and is no longer **using alcohol and therefore could be discharged** **[I/S]** **'s evidence was that** he had clearly recorded previously in the medical notes that her problem was not alcohol but cocaine and stated that she was probably alcohol free at this time. He also recorded in Beth'**s notes that she was using 0.5g to 1g of** cocaine 2 to 3 times a week whilst an inpatient at the Lakes so being an inpatient does not necessarily mean that one is drug-free. He was not consulted prior to the discharge and would have raised this if he had been. [Statement of **[I/S]** dated 12 November 2019]

5.56. On 1st December 2018 Beth was admitted to Colchester A&E after hitting her head on a stone object. She was discharged and asked to contact the Crisis line. She did so on 2nd December 2018 and said she would go to a bridge in **[I/S]** and jump from it.

5.57. On 3rd December 2018 Beth was visited by a community practice nurse and a healthcare assistant from the HTT and disclosed that she had been sexually assaulted . She discussed going to report the assault to the police with [I/S] [I/S] her care coordinator later that week.

5.58. On 6th December 2018 at around 11 in the evening Beth called the Crisis team and disclosed she had taken on overdose of [I/S] and had cut her wrists. She was conveyed to A & E by ambulance. She remained in the hospital for two days but was able to leave the A & E of her own accord on 8th December 2018.

5.59. On 7th December 2018 Beth's care coordinator [I/S] attended mum's house in order to support Beth with attending a further police appointment to give a statement about the sexual assault in September 2018. The police arranged to take a video interview on 14 December 2018. [Statement of DI [I/S] dated 15 June 2021]

Peter Bruff Unit Admission 10-18 December 2018

5.60. On 10th December 2018 Beth was admitted to the PBU and placed on level 2 observations due to self-harming using a [I/S] knife. She remained on the Unit for about 8 days during which there were multiple instances of self-harm, continued use of cocaine noted and an episode where she ligatured using a scarf. [Medical Records, Case Notes 10-18 December 2018].

5.61. On 11 December 2018 she was reviewed by Consultant Psychiatrist, [I/S] [I/S]. Dr [I/S] said in her statement to the inquest that "*her mental health had deteriorated since her discharge from Thorpe Ward*" and that she wished to remain on the Peter Bruff Unit. Dr [I/S] said in her statement that she asked the nursing staff to raise safeguarding with the safeguarding team of the Trust. [First Statement of Dr [I/S] dated 6 November 2019 and Second Statement of [I/S] dated 16 August 2021]

5.62. On 12 December 2018 Beth disclosed to a healthcare professional [I/S] [I/S] that she was being sexually exploited. According to a statement to the inquest by Safeguarding lead [I/S], she also expressed concern that Beth reported that she feared the man who was exploiting her would harm her if she went to the police. A safeguarding concern was raised by [I/S] and Beth was told by staff that they would file a SET SAF form . Safeguarding lead [I/S] was contacted and has advised that we record and discuss the situation for care coordinator [I/S] to pick up and continue to monitor. [Statement of [I/S] dated 23 January 2020]

5.63. A SETSAF 1 form regarding sexual abuse was completed on 12 December **2018, however this was not sent to the Trust's Safeguarding Team, which** should have happened. **This was flagged by the Trust's own Serious Incident** Report which says this was contrary to their policy, that there was no monitoring of this safeguarding concern, and as a result this was not forwarded to Essex County Council. Therefore no one was allocated the responsibility to coordinate the enquiry and the Safeguarding Team could not monitor whether the enquiry was being carried out correctly and within the timescales.

5.64. On 15 December 2018 Beth left the ward on leave. She contacted the ward to say that she was having wanted to extend her leave until 9 PM. However, she later called the ward to say she felt suicidal. She returned to the ward and was observed to be flat in mood. It is reported that around 6.10 PM staff responded to call bell and discovered that she had used a scarf to tie a ligature around her neck. The ligature was removed by nursing staff using ligature cutters. She disclosed to staff that she was terrified of a man exploiting her. [Independent Report dated March 2020].

5.65. On 17 December 2018 when Beth returned to the ward from leave she was found to be in possession of blades which were removed. We discovered in evidence at the inquest that Beth also contacted the police herself to say that she was at risk of being trafficked.

5.66. On 18 December 2018 Beth was once again reviewed by Dr [I/S]. In her statement to the inquest she says she was aware of the incident with a ligature the previous day but that she was also complying with the care plan and did not meet the criteria for assessment under the Mental Health Act in her opinion. She decided to discharge her after speaking with her care coordinator [I/S], and she considered there was no benefit to detaining her under section. Instead, her treatment plan would continue with her care coordinator in the community, and the plan was to have her follow up with Open Roads. In the ward review prior to discharge it was noted that Beth had deleted and **blocked the person who was exploiting her and had applied for a women's** refuge, however the notes also mention that she continued to use cocaine, having used cocaine while on leave from the ward during this inpatient admission, **and that she thought her symptoms had become "severe"**. Again we have very serious concerns about this decision making and the poor care that Beth received at a time when she was so unwell and vulnerable. [First Statement of Dr [I/S] dated 6 November 2019, Second Statement of Dr [I/S] dated 16 August 2021, Discharge Summary dated 18 December 2018]

Peter Bruff Unit 30 December 2018 - 3 January 2019

5.67. On 30 December 2018 Beth attended A&E again, having been brought in by a friend following threats to drown herself. She was eventually admitted to Peter Bruff Unit as an informal patient after initially saying she would return to **our mother's home**. She disclosed that she was still in contact with the man who had had been exploiting her and that she was staying with a friend who

was encouraging her to engage in sex work. She was placed on level 2 observations, to be observed four times an hour.

5.68. On 31 December 2018 a ward review took place where she was assessed by Dr [I/S]. This was attended by a member of the HTT named [I/S], including another Dr [I/S], specialist nurse [I/S] and psychologist named [I/S]. The clinicians decided , at the outset of this stay, to discharge her on 3 January 2019. This decision was criticised at the inquest and we remain as a family shocked that she could have been discharged without appropriate community care planning. [Statement of Dr [I/S] dated 31 October 2019 revised June 2021, Medical records case notes dated between 31 December 2018 and 3 January 2019, Discharge Summary 3 January 2019]

5.69. **While all of the events leading up to Beth's death are very distressing for us** as a family we are particularly worried that we were not informed about the following event, which was a serious near-miss at the time. It was only through the investigations into what happened that we were told about this near miss.

5.70. On 12.30 am on 1 January 2019 during a random check Beth was found having self-ligatured and having reached the point where she was visibly blue in colour and non-responsive. An ambulance was called due to the fact that she showed laboured breathing even after being cut down and she was taken to hospital. This behaviour was noted to be a significant departure from normal behaviour, as Beth usually raised an alarm if there was a possibility of her losing consciousness. The independent CCG report considered this event **to have been a "near miss"** although it was not recorded as such (see further below). The relevant case note from her medical records is exhibited to this statement. No-one in the family were informed about this near miss. [Independent Report dated March 2020].

5.71. On 2 January 2019 Beth **went on ward leave and came back to the ward"**. **The record oddly refers to her being "bright and settled"**. It is a concern to us

that the records often make comments about Beth's presentation without detailed interactions, assessments or consideration of the significant self-harm she had committed. Later the same evening she was found in her bathroom after pulling the buzzer with a dressing gown belt around her neck and **an item** in her mouth. We therefore strongly query whether she was **presenting as "bright and settled"**. It is recorded that her observations levels increased to Level 3. **This was regarded as a second "near miss" by the CCG** report but was not recorded as such (see further below). [Medical Records, Case Notes 2 January 2019]

5.72. To date, we have not been provided with any ward handovers and record of observations from this inpatient stay.

Datix

5.73. Over a week after the inquest had started, the Trust disclosed a spreadsheet of DATIX reporting. This was entirely new to us and had not been provided in the close to 5000 pages of medical records previously received. The Trust was criticised by HM Coroner about the late disclosure. Worryingly and shockingly to us, the Datix records showed that the Trust had recorded these incidents on 1 January 2019 and 2 January 2019 **as "not serious incidents"** and recorded the harm as **"no harm" or "low harm"** [DATIX reporting spreadsheet of incidents, undated]. It is further a concern that the DATIX data refers to a second incident of self-strangulation at 21.15 on 1 January 2019

5.74. This is how 1 January incident is recorded in the case notes:

Beth found on the floor on the side of the bed close to the adjacent wall with tight ligature in place round patient neck at around 0030. Beth was visibly purple and had burst blood vessels in her face. Ligature cut. Beth sustained minimal scratches to the back of her neck as a result. Beth was placed on enhanced observation level 2 4/60. Physical observation obtained o2 stats where low and unsteady. See track and triggers chart. Ambulance called due to a laboured breathing. Beth was only responding to loud talking, was not responsive to touch or pain when ambulance team arrived. Oxygen was given with a rebreathing mask although this proved only slightly

effective....Patient was taken to CGH A&E .. once in A&E Beth was taken to Majors where they requested a neck/head scan and a chest x-ray."

5.75. **The DATIX records this as "Not a serious incident** .. Low Harm.....Action taken... O2 stats where [sic] low and unsteady...her reactions where [sic] abnormal and she did not appear herself."

5.76. In summary, she was found with blood vessels having burst in her face, had to have an ambulance called because she was unable to breath and had to be administered a breathing mask, and had to be taken to the A & E. It is hard to see how this could possibly be considered by anybody to not be a not **serious incident with** 'low **harm**'.

The DATIX records that "I*t is known that patients with a long history of DSM including attempts at self-strangulation will attempt to use any available materials for this purpose* **[I/S]** *. It is virtually impossible to mitigate against every such incident without overly restricting the autonomy and personal freedom of the individual concerned.*" **We are not clear if this is** specific to Beth but we are left wondering what steps were taken to actually engage with Beth as an individual and care for her following this near death event.

5.77. The 2nd January incident is described in the case notes as follows:

Later on in the shift the bathroom buzzer was called. On arrival the door was blocked and could only open a short way. Beth was moved from the door and was found with a ligature in place. Beth was a deep purple shade and her legs where shaking. The ligature was cut off with difficulty as it was very tight and hard to get the cutters in-between. Beth also had put **an item** *in her mouth which was visible and easily removed. Observations were taken and all within range… It was explained to Beth that she would now be placed on level 3 observations as her safety could not be managed on level 2.*

5.78. **The DATIX records this incident as "not a serious incident" and "no harm."** Again we are astonished and horrified that this is how the Trust recorded these incidents.

5.79. While this information around Datix reporting causes us concern around how these systems were used, it also leaves us wondering how much of her care was driven by data (some of which was seemingly inaccurate and did not give a full picture of Beth's case) rather than engaging with her as an individual especially following these near death events.

5.80. We are concerned that there were two incidents in quick succession where **Beth was found having ligatured till she was 'blue in the face', both of which were considered by the independent investigators to have been 'near misses'**, which were incorrectly reported on DATIX by the Trust.

5.81. We are further concerned that the DATIX reporting spreadsheet refers to two ligature attempts on 1st January 2019, with the second attempt having happened at 9.15 at night. From the information on DATIX it appears to relate to the incident on 2 January 2019 however it is difficult to make sense of and it is not clear to us which record is accurate. h.

5.82. We are aware that inaccurate reporting on DATIX by the Essex Trusts has been a common factor in many inquests and is a constant source of frustration for bereaved families. In our joint submissions with legal representatives of other bereaved families we have noted that the charity INQUEST had put forward many examples of other bereaved families like us where Datix reports were not completed following absconding or ligature incidents and of cases in which even when Datix reports were completed, they were incomplete, inaccurate or limited details were provided. We echo the concerns raised in those submissions about systematic issues on DATIX. Insofar as the Essex Trusts are relying on searches of DATIX to provide the Inquiry with statistics about failings, any analysis of those findings must be made with utmost

caution and must be supplemented by hearing about the personal, lived experiences of those families that were affected.

Discharge

5.83. On 3 January 2019 ward staff proceeded to continue with her planned discharge, attempting to contact [I/S] her coordinator, and informing Reed services who attended to visit her that she would be discharged that day. An MDT Meeting took place and her observations were reduced to level 2. Despite everything that had happened and without any proper care planning for the community including safeguarding she was discharged to our **mother's home. Our mum was not told about the recent near misses**.

5.84. Dr [I/S] gave evidence at the inquest. As a family we disagree with his decision to discharge Beth which seems to be inappropriate and wrong. He said in his statement to the inquest that he had reviewed Beth on 31 December and that she where she showed no active suicidal intentions or plans, nor evidence of active psychosis of severe depression, and that this date had been agreed and that her care coordinator would be informed of her discharge. However it does not appear that the assessment from 31 December was updated following the two near misses which are not mentioned at all by Dr [I/S] in the discharge summary. [Discharge Summary 3 January 2019]

5.85. Her Discharge summary listed [I/S] as care coordinator, though it appears that the staff tried to contact [I/S]. She was discharged with her medication Pregabalin 200mg BD (pain), Omeprazole 20mg OM (gerd), Bisoprolol 1.25mg OM (high blood pressure), Ferrous Fumarate 210 BD (anaemia), Duloxetine 90mg (serotonin) and Lamotrigine 50mg BD (bipolar mood stabiliser). We are not aware of whether a 72 hour review took place .

Community 5-9 January 2019

5.86. During this period Beth lived with our mum at her home. As referred to above our mum has her own mental health diagnosis and there appeared to be little or no consideration given to this in the decision making; further the family were not informed by EPUT staff of the full events and risks including the near-misses. On 5 January 2019 Beth contacted a crisis line, reported she was suicidal and attended minor injuries the previous day. It appears she was advised to attend A&E but refused to do so.

5.87. On 7 January 2019 Beth attended an appointment with Open Road regarding her substance abuse. She stated she was struggling with mental health and drug use. **According to the Open Road's report, she told them that she had** been discharged **"despite" an attempted suicide, which suggests to us that** she herself did not agree with the discharge nor her treatment and care.

5.88. On 8 January 2019 the notes say that the Access and Assessment Team received a referral from Colchester Hospital. Beth had attended the Clacton Minor Injuries unit following further incident of self-harm by way of cutting and was sent to Colchester General Hospital A & E. An hour following assessment at hospital by the triage, Beth had gone missing from the hospital. The relevant record is exhibited to this statement [Medical Records, Case Notes 8 January 2019] It was reported to the police, but she came back to the hospital same day, with our mother, having taken another overdose. It is recorded that she told staff that she could not see the bright side to anything and that if she was sent home that she would take her own life. She was offered and accepted an informal admission and remained at the A & E until such time as they could find a bed.

9 -15 January 2019 Peter Bruff Assessment unit

5.89. On 9 January 2019 Beth was admitted to the Peter Bruff Unit at Colchester hospital as an informal patient and placed on Level 2 observations. She was

permitted to go on a period of leave a few hours later but after returning was found with a ligature around her neck which was removed by staff some hours following admission. The relevant records are exhibited to this statement [Medical Records, Case Notes 9 – 17 January 2019, Admission Summary dated 9 January 2019]

5.90. On 10 January 2019 she was assessed by Consultant Psychiatrist, Dr [I/S] [I/S] in a multi-disciplinary team meeting. She noted that Beth continued to feel suicidal and needs help with constant ruminating thoughts asking her to kill herself. She added Aripiprazole 10 mg OM and prescribed her Abilify Mantena depot.

5.91. On 11 January 2019 Beth was deemed high risk of suicide following review by Dr [I/S] and was advised that she remains in hospital.

5.92. On 11 January 2019 Beth was assessed by Dr [I/S] who said in her statement that she found her very subdued in manner with constant ruminations of wanting to kill herself. She was keen to stay on the ward as she felt safe – Dr [I/S] considered detaining her under section but decided as she was staying there informally there was no need. She changed her medication to address her mood, prescribing her oral Aripiprazole, and also had her agree to take Aripiprazole in long acting injection form.

5.93. It seems that no consideration was given after this to detaining her under section – 19 November 2018 was the last time as far as we are aware that she was detained under section. We had always trusted her treating clinicians to make the right calls regarding her treatment including whether she should be detained voluntarily or not. In those last few months, Beth seemed to be **desperate to stay on as an inpatient but the Trust's policy seemed to have** changed toward her preferring to limit her inpatient stays to short-term ones. Had we known what we know now about the two near misses in January we would certainly not have agreed to her discharge. We only found out about

these after the independent investigation. Our mum knew something about these but the severity of the attempts were never made clear to her.

5.94. On 11 January 2019 Beth used a period of leave to meet up with the man she said was exploiting her. As a family we find the failure to safeguard Beth when she was in hospital very disturbing. A healthcare assistant [I/S] who was working that night said in her statement to the inquest said staff spent a long time deciding to allow her to leave, but ultimately it was decided she had capacity and was not actively reporting self-harm intentions. When she returned at around 7.15 PM, staff said she was visibly upset, having returned without any trousers. She subsequently reported that she had been sexually exploited and assaulted. She reported it to the police who came to the ward and took samples. They arranged to meet her the next day to take her to the police station to take a statement. [Statement of [I/S] dated 12 June 2021]

5.95. On 12 January 2019 Dr [I/S] attended the ward and learned about the incident on 11 January. She conceded that this incident should have prompted a review of Beth's **status under the Mental Health Act. As it stands, this should** have completed [Statement of [I/S] dated 6 November 2019]

5.96. On 12 January 2019 Beth had a forensic examination with the police. PC [I/S] spoke to [I/S] & [I/S] at PBU. A nursing care assistant contacted our mum to tell her that Beth had been assaulted because Beth could not do so herself. Our mum was very concerned and contacted Beth to see if there is anything she could so. **Our mum's statement dated 19** December 2021 is exhibited to this statement. Ultimately Beth agreed to go with her to Pizza Hut, where our mum found her to be extremely withdrawn in contrast to her normal chatty self. She would not tell her what had happened. She returned her to the ward at 8 PM, only to be contacted later on to be told that here had been another incident with a ligature.

5.97. On 13 January 2019 an a police officer named DS [I/S] contacted the unit and she spoke to [I/S] about Beth's mental health history. Police then attended and she was interviewed by police regarding events of previous day.

5.98. She then met our mum again at around noon and went out with her, returning at 2 PM. She later disclosed that she had self-harmed with a [I/S]. Our mum said she continued to be withdrawn and on edge, in contrast to how she usually was.

5.99. On 14 January 2019 Beth went on leave with a support worker from Reed [I/S], to whom she gave her account of the alleged rape on 11 January. Our mother picked her up. She returned from leave at around 8.15 pm where she was searched. She went out for a brief period of leave and returned at 9.30 after which she was searched on return and two hairbands were found. Then at 10 pm an alarm sounded. According to records, Beth had cut crook of her arm with razor blade and was taken to A&E. She admitted to having **concealed the blade on her** Beth returned to PBU and was put on level 3 observations. The relevant medical records are exhibited to this statement [Case Notes, 14 January 2019]

5.100. This was a serious incident of self-harm, and shockingly, our mum she was never informed about this. We only found out about this during the investigations after her death.

5.101. On 15 January 2019 there was an MDT meeting where Beth told staff she had taken an overdose and then told staff that police were investigating her being a possible sex trade victim. She admitted she was taking £200 worth of cocaine per week. The family were not informed about or contacted by the MDT.

Transfer to Thorpe Ward Basildon hospital

5.102. On 15 January 2019 a sit rep meeting was held about the availability of beds on the Peter Bruff Unit. There were no beds for Beth to stay the night but a bed was available at the Thorpe Unit at Basildon Hospital. Consequently it was decided that they would transfer her. We exhibit the statement of [I/S] who gave a statement to the inquest regarding this. [Statement of [I/S] dated 13 January 2020]

5.103. Our mum was not informed about this transfer. She finds it difficult to drive to Basildon Hospital because of her own health problems, and had she known she would have visited Beth at the Peter Bruff Unit.

5.104. Beth's transfer between the Peter Bruff Ward and Thorpe Ward was carried out by Delta Medical Services, a private patient transport service, at around 11.11 am. She was accompanied by two staff from Delta but no staff from Peter Bruff went with Beth and no hardcopy paperwork was included in the transfer. From what we are aware, the decision not to send any staff is all the more perplexing given that no staffing issues were reported on the day – in fact, **according to the Trust's own Serious Investigation Report**, Peter Bruff **ward reported themselves "green" indicating staffing levels were good**. [Root Cause Analysis Report dated 3 July 2021 amended 27 August 2021]

5.105. From what we understand from evidence at the inquest, Delta staff were given a verbal handover by Peter Bruff staff, however no risk issues were reported to them. Beth arrived at Thorpe ward at 12.20hrs. EPUT admitted in the inquest that Beth should have been accompanied by a member of staff from Peter Bruff Ward and there should have been a full handover before transfer. It was admitted that this failure more than minimally or trivially contributed to her death . From our perspective this is further evidence of the clear lack of consistency in her treatment, there was never any clear communication of her risks.

5.106. According to evidence at the inquest the Ward Manager [I/S] and Consultant Psychiatrist Dr [I/S] at Thorpe Ward they received no prior notice of the transfer. They both gave evidence at the inquest that they were surprised she had been transferred and to see her. We exhibit their statements here. In fact **the WM's evidence** to the inquest was that, having been ward manager since March 2018, by 16 January there had been 4 or 5 other occasions, he estimated, where a similar transfer had happened without sufficient information or notice. [Statement of **the WM** dated 6 November 2019, statement of Dr [I/S] dated 1 November 2019]

5.107. From what we understand, in the absence of any handover, the only way Thorpe Ward could then familiarise themselves with Beth's **case history was** through the medical records. However, it emerged that both wards had different software systems for their medical records, called PARIS and MOBIUS. Users on one system could not view documents saved on another **system. This meant that the staff on Thorpe Ward had no way to check Beth's** history or familiarise themselves with the number of very recent attempts at self harm, on the 12,13th and 14th **of January. Even the Trust's own Serious** Investigation Report found this to be a failing [Root Cause Analysis Report dated 31 July 2021 amended 27 August 2021], saying at paragraphs 50-51 that

*The Trust currently has two patient information systems one in north Essex (Paris) and one in south Essex (Mobius). There is a system called Health Information Exchange (HIE) that sits in between Paris and Mobius and certain documents and information are automatically pulled from both systems. However the investigating team have identified that staff are not all trained and confident in the use of the HIE system. In addition, the HIE system does not migrate case notes from Paris or Mobius and therefore information regarding patient risk, treatment and care that is included in case notes does not get migrated to HIE. **Regardless of HIE's limitations, staff do not regularly access the system and rely***

on verbal and emailed handovers. According to the HIE Team the following documentation was migrated over:

5.108. In the absence of any medical notes, it fell to Beth to self-disclose to a consultant psychiatrist that she had self-harmed and ligatured the previous day, had been sexually exploited and had a plan to kill herself. She was assessed as at high risk of suicide and self-harm. We only found this out from her medical records [Medical Records, Admission Assessment dated 15 January 2019]

5.109. The unit had individual rooms for high-risk patients. At 1.05 PM on 15 January 2019 a nurse named **[I/S]** carried out an assessment she was deemed high risk of suicide and self-harm. At 2.25 PM she was reviewed by Dr **[I/S]** and was put on Level 2 observations – a reduction from Level 3 which she had been on at Peter Bruff Ward. She was placed in a female **dormitory with seven beds**. Dr **[I/S]** **'s risk assessment recorded** "*there is a high risk of deliberate suicide as compared to the general population due to her previous history of suicide attempts.*" [Medical Records, Case Notes 15 January 2019, Statement of **[I/S]** dated 22 June 2020, Statement of **[I/S]** dated 26 June 2020]

5.110. Our mum says she spoke to Beth on the phone who told her that she had already been given a discharge date on 22 January 2019. She found this to be unbelievable, given even what she knew at the time about the escalating incidents of self-harm. She also says that Beth was upset about this. As we have set out setting fixed discharge dates was wrong.

5.111. On 16 January 2019 Beth was granted a period of leave in the morning. The following decision making **continues to be incomprehensible to us. Beth's** observations levels were reduced at around 12.30 to level 1. The justification

provided in the statement of Dr [I/S], was that she had gone on leave without issues and was an informal patient. We cannot understand this decision.

5.112. Beth was found around 7.43 pm, having tied a white scarf around her neck [I/S]. The evidence from the inquest was that resuscitation attempts were made but were unsuccessful. One of the questions we have raised throughout is why and how Beth had a scarf given the real and known risk of suicide.

5.113. We found out afterwards that a Nurse, [I/S] did not complete the his observation record that evening, and we do not accept that he did do the observations as he was supposed to. We found out later that he was actually called back, after Beth died, as he had gone home at the end of his shift to complete the observation record. This is extremely troubling and we make some further comments on this below.

Part Two

6. We set out below our specific responses to the questions set out in the Rule 9 questionnaire dated 3 March 2025.

7. Diagnosis

7.1. As we have said above, Beth was involved with the CAMHS service when she was a teenager.

7.2. Beth received her diagnosis of ADHD as a child around 2004, through the Ipswich Child and Adolescent Service. [Letter by Dr John Guille to St **Benedict's** dated 7 August 2005]

7.3. It was the last three years of her life that her mental health significantly deteriorate. The factual background to her admissions we have set out above also provides an overview of how her mental health became worse over those last three years. The death of our father Dr John Guille on 28 October 2018

was a major trigger. There was a significant increase in serious attempts by Beth to end her own life following this, with her taking an overdose only a few days after our father's death, such as the serious 'near misses' we have described above whilst at the Peter Bruff Unit on 1st and 2nd January 2019.

7.4. Beth was provisionally diagnosed with Unstable Personality Disorder ('EUPD') on about 18 January 2016 following an inpatient assessment. The treating clinician noted from her presentation that the "impression" was EUPD and this diagnosis seems to have been "held" in all subsequent interventions. [Medical Records, Case Notes dated 18 January 2016] The Independent Investigation stated that diagnostic processes were lacking when arriving at a diagnosis of Emotionally Unstable Personality Disorder. The report found that a structured interview tool was not used in arriving at the diagnosis of Emotionally Unstable Personality Disorder in line with recommendation from NICE Quality standard recommendation which was published in June 2015. [Independent Report dated March 2020].

7.5. The family formally made submissions in the inquest that requesting that EPUT make a formal admission in relation to the finding of the independent report regarding the lack of a proper diagnostic pathway. We cited the following from the report [Independent Report dated March 2020], at para 10.17:

"It is evident that no holistic formulation was developed that took into full account Ms A's [Beth's] emotional, physical, mental health and social needs. This was exacerbated by the lack of true multidisciplinary working over time. Consequently it is difficult to understand how protective factors, triggers, and relapse indicators were identified for Ms A and how these were understood in order to maintain her wellbeing and promote her safety."

The report went onto say at para 10.20:

"The lack of a robust diagnostic formulation, in our view, was the most probable cause for the failure of all subsequent care and treatment interventions."

7.6. That there still is no pathway for EUPD is most disappointing of all; both Sarah and Julia were involved in a working group several years ago set up by North East Essex CCG specifically to inform a pathway for patients with a diagnosis of, what was then known as Borderline Personality Disorder (BPD). This was set up because support for these patients, from the mainstream EPUT services (then North Essex Partnership Trust), was recognised by commissioners and service users alike, as lacking. The Haven Project, which Beth used, is a specialist treatment service in Colchester for those with BPD/EUPD. Julia **[I/S]** had over the years benefitted enormously from their intensive input, to the point that we as a **family credit The Haven with 'giving us our mum back'. The Haven Project** was having their funding cut by NEE CCG as not enough patients were benefitting from the service. Sarah complained to the CCG about these cuts **and was invited, with Julia, to a workshop held at the CCG's premises in** Witham. A number of other service users and carers were also present. Nothing further was communicated by NEE CCG on this work, and it seems that it was not taken forward by EPUT or NEE CCG. This leaves us with yet another unanswered question, wondering what may have been different for Beth if this work had been taken seriously by both the commissioners and the provider.

7.7. The family also felt that concerns raised with regards Beth**'s medication regime should have been included in EPUT's** formal admissions and we had in fact made submissions on this point.. The Independent Investigation report states at para 10.28 [Independent Report dated March 2020]:

*"It would appear that the medical response to Ms A's EUPD/BPD was managed poorly over a period of years. This method was neither effective nor entirely safe (on multiple fronts). Whilst a combination approach (medication with psychological therapy inputs) was indicated – **Ms A's medication regime** appears to have been difficult to justify at times and went against national best practice guidance. A significant omission was that detailed symptomology*

(with clear criteria) were not identified prior to medication regimens being developed. This means that clinicians did not have a recorded plan with regard to the symptoms they hoped the medication would effect. This indicated that medication reviews might not have been as effective as they needed to be and at times caused Ms A to experience significant side effects and over-sedation."

7.8. We agree with the independent report that fundamentally, there was an emphasis on simply treating Beth's physical symptoms with a view to discharging her rather than trying to properly understand the underlying issues which caused her to deteriorate in the way she did. There was no effort to try and understand her triggers and protective factors so that she could keep herself safe and that her mental health would improve. [Independent Report dated March 2020]

8. Assessment

8.1. We have set out a detailed factual background of the various inpatient admissions Beth had with details of incidents where she was detained under section further to an assessment under the Mental Health Act and others where she was detained informally. In relation to the question of whether there were specific instances where we think she should have been assessed in the community for an inpatient admission, the answer to that because as you can see in the last three year period that she had so many sections and self-admission and discharges that it was hard to know the comings and goings when she was so unwell – so cannot pinpoint a time she should have been admitted and then she was not. Further there were times when we were unclear about discharge, that is whether she was considered to be better or whether it was due to space.

8.2. Our overall concern in the lack of consistency in care and treatment. There was no oversight and planning about admissions or discharges. It was all lurching around from crisis management without proper consideration of the particular circumstances, her co-morbidities being substance misuse and how that was managed. There seemed to be shift so that Beth was told when she

would be discharged; these targeted dates for discharge which we raised concerns about. We believe these created pressure on Beth. We do feel that after Beth's eight-month long admission to the Lakes in 2018 there was a change in approach where when she was admitted the treating staff would set discharge dates and stick to them. We believe that this was unsettling for Beth. Target dates for discharge did not consider the severity of her situation or may have made her feel like a failure if she did not 'meet' the target dates

8.3. In general, our concern was that in general that on the instances where she was an inpatient, that she would continue to self-harm on the ward, in many cases requiring a physical care as set out above, but there would rarely be a further risk assessment carried out or an further assessment carried out in relation to this – at best, what they would do is increase the observations was under. These incidents did not seem to affect the Trust's discharge plans, and in our view she was discharged in situations where she should not have been.

8.4. In relation to the admission from 30 December 2018 to 3 January 2019 which we have discussed above. We were deeply concerned and shocked at the fact that no further assessments of her mental health were carried out further to the two "near misses" on 1st and 2nd January 2019 whilst she was on the Peter Bruff Unit. These were both serious attempts by Beth to take her own life, with it being noted in relation to the 1st January 2019 incident that she did not attempt to call a nurse before losing consciousness, something she always did.

8.5. We submitted in the inquest that the failure to carry out a risk assessment or a mental health assessment further to these two incidents should have been formally admitted as a failing.

8.6. We agree with the finding of the independent report on para 10.62 that: *"It is extraordinary to see that during Ms A's last few weeks (especially in view of*

two extremely serious self-ligature events – both of which could have caused her death) no in-depth risk assessment was undertaken or management plan put in place. It would appear that services had developed a very high tolerance threshold when dealing with ***Ms A's behaviours at this time and that*** *discharge was imminent days before her death. It was entirely predictable that Ms A would continue to escalate her behaviours as it was evident that she was highly distressed and totally out of control."* [Independent Report dated March 2020]

8.7. The report went onto find at para 10.121 that it is not clear "*why these two serious attempts at self-strangulation had not led to a risk assessment and* ***review of Ms A's status under the Mental Health Act*** *– during previous admissions this would have been an automatic response; this time it was not – Ms A was discharged on 4th January 2019. Both incidents should have been considered near misses and have been subject to full investigation"* [Independent Report dated March 2020]

8.8. We as a family completely agree. It is beyond belief that despite these two incidents that they stuck with the original discharge date of 3 January 2019 and did not assess Beth with a view to detaining her under the Mental Health Act. The first time we found out about these two near misses was in the independent report and it shocked us to the core. It seems that no consideration was given to reviewing her discharge date at all. These two near misses should have prompted an assessment of Beth**'s status under the** Mental Health Act.

8.9. In addition Dr **[I/S]** said in the inquest that she would have assessed Beth under the Mental Health Act on the 12th January 2019, after finding out about the incident on 11 January. In the inquest, we as a family submitted that the Trust should have admitted that there was a failure to carry out a risk assessment

8.10. We exhibit all of Beth's **assessments under the Mental Health Act for details** of who caried out the various assessments. [Mental Health AHMP Assessments dated various]

9. Inpatient Admissions

9.1. We once again refer you to the detailed factual background which provides a timeline of Beth's **various admissions and the circumstances of each** admission.

9.2. The following admissions were under section:

i. Admission on 13 May 2016 to Ardleigh Ward following an attempted overdose. She was initially detained section 2 Mental Health Act before this was changed to section 3 on 9 June 2016. She was discharged on 25 July 2016.

ii. On 21 October 2016 BL she was detained under S3 MHA and on 31 October 2016 she was transferred to the Peter Bruff Unit, under S3 MHA, and discharged on 12 December 2016

iii. On 19 January 2018 Beth was initially detained at Ardleigh Ward under section 2 of the Mental Health Act before this was changed to section 3 on 15 February. Her section 3 expired on 30th July 2018 after which she remained on Ardleigh Ward until 13 August 2018. Beth unsuccessfully challenged this detention under section

iv. On 14 November 2018 Beth was detained under section 3 of the Mental Health Act following an assessment by Dr **[I/S]** at the Peter Bruff Unit, having been informally admitted the day before. She was transferred to Thorpe Ward on 15 November 2018 under section 3. Her section was rescinded on 19 November 2018 after which remained at Thorpe Ward as an informal patient until her discharge on 22 November 2018

9.3. As far as we were aware, she was never formally detained under section after 19 November 2018.

9.4. We are not aware of any incidents in particular where Beth wanted to be admitted and admission was refused, though as set out in the general factual

background there was some instances where she attended the A & E after a self-harm attempt and was sent home. We are concerned that there was an overall failure to provide therapeutic long term care for Beth's serious mental illness and instead the system seemed to function by lurching from one crisis to the next without any informed care planning.

10. Ward Environment

10.1. In the Lakes when we went to visit Beth we noted that there was not much stimulation in the environment. There was a timetable but it had nothing on it. That was very little in the way of activities. For long term residents, it did not seem that they provided structure. There were no groups that we were aware of, except from what we recall a news group in the morning. There was a gym but it was hard to book a session at the gym and there was rarely any capacity for gym . The smoking ban was also difficult for Beth as had to leave the ward in order to go and have a cigarette. This would mean she would take ward leave to go out and smoke. However this put her at risk as she would use periods of leave to engage in self- destructive behaviour. In other places the nurse would come and collect the smokers and take them outside.

10.2. Our sister, Sarah mentioned when she was in the Lakes and whenever she would go in there and ask her, 'What did you do today?' Beth would say 'Nothing,' every single day. There didn't appear to ever be anything in place to even occupy her. The only regularity appeared to be, from our perspective taking medication and meal times, in addition to the newspaper group we mention above. [Transcript, Evidence of Sarah Back to Non Statutory Inquiry, 13 December 2021]

10.3. Our mother and Sarah gave evidence in the non-statutory inquiry about her not having sheets 'half the time'. The reason they would give is this is because they were afraid she would do something with them, but then there didn't seem to any plan to manage her risk if she was at such serious risk of self-harm.

10.4. As set out above, our father wrote a complaint letter to the Lakes during the eight month period of detention, in which he highlighted several concerns regarding her treatment whilst she was on the ward. He highlighted the fact that she continued to self-harm despite being on the ward, and that we never received any updates about her treatment, even when her section was discharged.

10.5. Our father did point out in his complaint that during her time there Beth came into contact with a person on the ward who was responsible for smuggling drugs into the ward and would bully other inpatient users of the service.

10.6. As we have said before, it was during her time at the Lakes that Beth met people who were bad influences on her and encouraged her to smuggle illegal substances into the ward. It was around this placement that these issues started. It was also here that she entered into a suicide pact with another user.

10.7. We recall that when visiting Beth while she was on the Thorpe Ward **that it 'felt' unsafe.** . We **can't really say way but one thing was the cohort of male patients** mixed with women. It did not feel safe. We can't **recall being signed in when** visiting her. The environment did not feel therapeutic. The staff did not engage with us and there did not seem to be many staff around. It took a long time for the buzzer to be answered. The reception areas seemed often to be empty. Overall it felt unsafe. It is hard to pin point any one thing but was our impression.

10.8. Our general impression of Thorpe Ward was that it was bleak. Not only were there few staff present, but it felt small and cramped. Other patients were loud, making lots of noise with no one intervening. When we picked up or dropped off Beth there was no staff to greet or handover.

10.9. It was quite different for example when we visited Clacton hospital when our mum was cared for there. The nurses were nice and friendly, there was recognition and a hello when they saw you, but that just didn't happen.

10.10. Regarding the Peter Bruff Unit, our recollection was that it felt calmer There was a greater presence of staff and our impression was that it was safer.

10.11. In terms of meeting Beth's basic physical needs, we don't think there were issues with any of the wards. All of them were stocked with food and medication and there was some staff presence on every ward.

11. Staffing Arrangement, training and support

11.1. One major issue that we felt in relation to the staffing generally on all the wards was the high proportion of agency staff. They would be quite noticeable as they had different uniforms. There seemed to be quite a high turnover of this staff and it was hard to know who was caring for Beth at any time.

11.2. We have been asked what we meant when we felt that staff were just 'winging it.' Our general impression on Ardleigh ward was that there did not seem to be any fixed processes in place to manage Beth's risk. There would be serious suicide attempts which we were not informed about which would only be acknowledged by changing observation levels, but then these would be changed back without any rhyme or reason. Sometimes following an incident where she had just been to the A & E following a serious self-harm attempt there would be staff sat outside her room and sometimes there would not be. Some of the staff could be quite unprofessional. Sarah and our mother recall one of the nurses saying on one occasion, just after one of these serious self-harm attempts requiring a hospital admission that if they hadn't been her

treating staff she would have been 'best mates' with Beth. Whilst this sentiment may have been well intended it showed a lack of empathy and professionalism.

11.3. When to came down to things like managing Beth's observations levels we note these were always changing and not making sense. We would sometimes visit her after she had carried out an attempt to take her life and said she would have died had not a nurse seen her, but on these occasions there would not be a nurse in sight. It was not deemed enough for a serious observation level.

11.4. We suspect a lot of the above was precisely because of the high proportion of agency staff and the turnover meant that everyone treating Beth had not been properly trained.

11.5. We felt that that communication was poor from staff on all wards. There was never any communication to the family when her risks were re-assessed or re-valuated and it was never made clear to us her level of risk at any time. There was also a lack of consistency in Beth's treatment – a lot of different people working with her and didn't have the same common understanding re her risks. There was also an inconsistent approach towards observations and discharge planning.

12. Care management and plans

12.1. One point that our sister Sarah made in the non-statutory inquiry was that despite readings tens of thousands of pages of medical notes in preparation for the inquest, we never once saw a care plan or any kind of overarching plan in place to actually make Beth better.

12.2. There was a balance between community care at home and being in what often felt like a random mental health hospital ward. Beth was quite often

unsettled by the ward environment. The lack of consistency across the different ward settings and the lack of stimulation on some wards also did not help.

12.3. From the medical records, as detailed above, there do appear to have been some instances where EPUT have recorded that Beth was involved in some of the decisions around her care. For example, she was involved in MDT meetings around her discharge, and fed into medication reviews. However we are not sure the extent to which she meaningfully participated in these decisions. For example, following the appalling decision to release Beth on 3 January after the two 'near misses', she told the Open Road assessors that she had been discharged even though she had tried to take her own life, which suggests she did not fully understand why.

12.4. We have also mentioned above the poor communication we had from staff generally but our mother Julia was involved in some of her discharge reviews and reviews on the ward. She was the only person who ever was invited to come to the reviews. She says that the staff never really spoke to her in the reviews. She would just sit there listening. She always felt a bit awkward and as though she wasn't really welcome there, as if her presence was annoyance. In any event the lack of communication made it so that she could not effectively participate in any of these reviews. They never let her know when she'd tried to commit suicide. Especially towards the end, where there multiple serious attempts to suicide whilst she was on the ward, we simply were not informed. Without this information, we would not have been able to participate in these reviews effectively anyway. [Transcript, evidence of Sarah Back to Non Statutory Inquiry 13 December 2021]

12.5. We also don't see, from the records or from any of the evidence in the inquest, that any of Beth's care plans changed after our father's death on 28 October 2018. Clearly, this had a huge impact on Beth and she became much worse

after this, however, there does not ever seem to have been any change in the trust approached her treatment.

12.6. Beth's treatment in the community often felt it was unstructured. As set out above, she was managed variously by the HTT, the SMHT, by Reed Care, and the Dual Diagnosis team, but it seemed that they had very little communication with each other. This was all overseen by a care coordinator. However, it is unclear how much these various teams would be communicating with each other. For example, as set out above, the decision by [I/S] of the Dual Diagnosis team without informing her care coordinator or indeed even [I/S] who had previously been dealing her. [Statement of [I/S], Dual Diagnosis Team dated 12 November 2019]

12.7. When she was in the community, her home treatment team and the social carers would make seemingly random suggestions that Beth should try kick boxing or dancing or something. Beth would quite often find this infantilising.

12.8. We as a family agree with the findings of the independent report in regards to the care planning by EPUT, namely that it was a reactive and mechanistic process and failed entirely at making her better. [Independent Report dated March 2020] There seems to have been no consideration given as to whether the care was effective and a complete lack of institutional curiosity about addressing the underlying causes of her deteriorating mental health. If anything, she got worse under the care of mental health services over the three year period ending in her death. We adopt the finding at para 10.61 of the report that:

"The general impression provided by the clinical documentation in relation to risk assessment and care planning is poor. A very mechanistic and reactive approach appears to have been taken. The Independent Investigation Team found it surprising how ineffective risk assessment and care planning processes had been in keeping Ms A safe and well. It is a fact – none of the interventions over the three-year period that Ms A was under the care of

mental health services served to improve her situation – it is incontrovertible that she continued to grow worse. Obviously the reasons for this were multifactorial – however the treating teams should have realised at a much earlier stage that the approach which kept being rolled out over and over again was ineffective and unable to effect change. To this end a complete transformation of thinking was indicated."

12.9. We agree with the independent report that it felt that her care and **management in the community was somewhat random, with seemingly "cut and paste" plans which had nothing to do with her needs. We adopt the finding** of the report at 10.67 [Independent Report dated March 2020] that :

"We found the care plans to have been largely cut and paste with few meaningful objectives that were not in sync with the risk assessment and management process."

13. Treatment

13.1. As we have stated above and elsewhere, we believe Beth**'s mental health** was mismanaged the entire time she was under the care of EPUT, from her initial diagnosis to all therapeutic decisions relating to her care. As the independent report concluded ***"the lack of robust diagnostic formulation…was*** *the most probable cause for the failure of all subsequent care and treatment* ***interventions."***

13.2. One of our concerns with Beth**'s treatment was how EPUT dealt with her** medication. Essentially, we believe she was overmedicated, indicative of an approach where the focus was on treating her physical symptoms rather than the underlying condition.

13.3. she was like a zombie at times. She was normally so silly, funny and relaxed, but that all of that was gone from being so dosed up. As we referred to above a side effect of the medication, she began putting on weight in the months leading up to her death.

13.4. Despite being on all that medication, she did not get better or stop harming herself.

13.5. The independent investigation concluded that the complex medication regime that had been set in train over the years and is considered by the CCG at this time was "*difficult to justify*" given the lack of a robust diagnostic formulation, that the regime *"not as effective as it might have been"*. [Independent Report dated March 2020]

13.6. The independent investigation concluded that it was difficult to understand what symptoms the various medication was being used to affect given the poor diagnostic processes, or how the risks from the medication regime were being monitored. [Independent Report dated March 2020]

13.7. At one point in August 2018 Beth was prescribed Duloxetine (antidepressant), Procyclidine (for medication side effects) bisoprolol (for high blood pressure) 1.25mg twice daily, Omeprazole (digestive disorders) Aripiprazole (antipsychotic drug commonly used for mood disorders) 5mg mane, Ferrous Fumarate (iron supplement) 210mg twice daily, Zuclopenthixol Decanoate (antipsychotic) 300mg IM every 2 weeks, Zolpidem (sedative/hypnotic) 10mg prn nocte and Clonazepam (benzodiazepine) 1-2mg prn (as needed) twice daily. On her discharge on 3rd January 2019, she was prescribed Pregabalin 200mg BD (pain), Omeprazole 20mg OM (gerd), Bisoprolol 1.25mg OM (high blood pressure), Ferrous Fumarate 210 BD (amenia), Duloxetine 90mg (serotonin) and Lamotrigine 50mg BD (bipolar mood stabiliser)

13.8. She was therefore prescribed a combination of mood stabilisers, antipsychotics, antidepressants and benzodiazepines. As the independent report stated, it was hard to see the justification behind these medication regimes. We understand that mood stabilising drugs are usually recommended for bipolar disorder, but she was never diagnosed with such a disorder. Antipsychotics were also difficult to justify given that she was never found to have psychotic symptoms. Though antidepressants are used to treat

EUPD, the rationale for prescribing them was never made clear on the clinical record.

13.9. One concern we had was the decision to prescribe Beth with benzodiazepines, despite the fact that she clearly had a problem with addiction. Among our family we have a registered paramedic, a qualified pharmacy technician, a nurse, and two seasoned GP receptionists who worked closely with our late father when he practised as a GP. We are all aware that it is extremely unwise to prescribe benzodiazepines to an addict, and are alarmed that EPUT did not consider this to be a problem. In their ***"factual accuracy response"*** **to the independent report**, [Factual Accuracy Response by Dr Milind Karale and Prof Natalie Hammon dated 24 January 2020] EPUT stated that Beth was not considered to be an addict by the staff who cared for her. The family strongly dispute this and are at a loss to understand why this statement was made. Beth was open about her dependency on cocaine, which increased dramatically in the weeks and months before her death, and she refused any support to stop using because, in her own words, she 'felt like herself' when she used. It was a great concern to us that her treating clinicians could not see what was obvious to us. [Letter to **[I/S]** of Thurrock CCG by family dated 6 April 2020]

13.10. We are concerned that not only was there no plan to address her addiction. Indeed, the Trust insisted even after her death that Beth was not considered to be an addict- but a complete lack of understanding on the part of the Trust regarding Beth**'s deterioration and escalating behaviours. Part of this was** failure to try and understand whether there were other mental health conditions which could potentially affecting the way Beth was presenting. Her diagnosis throughout was just EUPD, even though she was being treated throughout with antidepressants, antipsychotics, and mood stabilisers. The independent report noted that it was rare to have a stand-alone diagnosis of EUPD without any comorbidities:

However the NICE guideline on Borderline Personality Disorder (2009 and amended in 2018) states that "The level of comorbidity is so great that it is uncommon to see an individual with 'pure' borderline personality disorder (Fyer et al., 1988a)". The statistic given is between 3 – 10% of patient populations)

13.11. The independent report goes onto say that at paras 10.11 through 10.13 that from a review of the records, it is possible that Beth suffered from **antisocial behaviour disorder, depression and a "significant" substance abuse** problem, which they consider should have been a more primary focus of her treatment. It concludes that:

There is no evidence of any systematic formulation process that would have helped to understand Ms A's co-morbidities better together with a realistic risk assessment and profile, neither was there the proper use of differential diagnoses in the early stages of Ms A's contact with services.

13.12. It has always been clear to us that there was a failure on the part of the Trust to accurately diagnose the underlying issues responsible for her presentations and deterioration over those last three years. We all saw that there was no improvement in Beth in the Lakes whatsoever after that long 8 month stay in 2018. There was, quite simply, no progress – she just came out as she had gone in. We actually feel like that long stay was detrimental rather than helpful, as she was never the same after that. She kept trying to take her life and she would either be sent home from the A & E or to a hospital, occasionally under section, to be discharged in a few days. It felt like she had been institutionalised, going through the same motions with no effect.

13.13. As we have stated elsewhere, one thing which did change after her long stay in Ardleigh Ward was the emphasis on having targeted dates of discharge, which would be announced to Beth at the outset of each stay. It was strange she was told she could be discharged the next week if she was

behaving – so this was not really taking the appropriate approach to her overall care, which seemed to be geared towards meeting these targeted dates than Beth's needs. Sarah said in the non-statutory inquiry, we personally feel that she used inpatient stays as a way of feeling safe and we think that when they changed the way that they were planning her discharge, in that manner, really unsettled her. As such we do not believe that Beth felt as safe as she had been as an inpatient previously.

14. Safety

14.1. We have been asked about whether there were any issues about Beth being subjected to abuse by members of staff or other inpatients. We are not aware of any incidents involving members of staff or inpatients. We have however set out our concerns regarding her safeguarding in the factual background above. She was able to leave the ward to apparently engage in sex work and despite her confiding this to multiple treating clinicians she continued to be able to do this. She also raised issues with being exploited by a certain man whom she identified and though there seem to have been plans to make a safeguarding referral this was never actually done. This of course led to her being assaulted during a period of leave on 11 January 2019, days before her death. As we have set out above a member of staff even raised concerns about letting her go out on leave on this occasion. In the statement of [I/S] [I/S] in the inquest, she talks about staff having a meeting about letting Beth go on leave on 11 January 2019, specifically because she had informed staff that she was going to meet the person who had been exploiting her in order to pay him money she owed him, and because she had £120 in cash on her which also raised concerns about her burying drugs, as it was week known by this point that she was using leave to buy drugs. It was ultimately decided that as she was an involuntary patient and had capacity they could not prevent her from leaving.

14.2. We have been asked to list the various incidents of self -harm or attempted suicide whilst she was on the ward and refer to Part One of this statement.

14.3. We have been asked whether Beth ever disclosed concerns about other inpatient users. There was an issue of bullying raised by our late father Dr Guille in his complaint letter about the service user [I/S] which we have described above during the eighteen month stay at the Lakes. However our concerns mostly were that on during that stay in Ardleigh Ward she seems to have come into contact with people who were a bad influence on her, with whom she seems to have taken turns smuggling illicit substances onto the ward and where she meets to have met a service user with whom she entered into a suicide pact with.

14.4. One of our concerns were the ease with which Beth could just take leave from the wards and obtain items which put her at risk. For example, there were two instances in December 2018 when she was detained on the Peter Bruff Unit – on the 10th and the 15th- where she was able to ligature with a scarf. We do not understand, how, given her risk profile was she allowed to bring scarves into the ward.

14.5. On 14th January 2019, less than two days before her death and two weeks after the two near misses in early January, she was able to smuggle a razorblade onto the Peter Bruff Unit and cut her arm with it. She had a well-documented history of using these periods of leave to either engage in risk-taking behaviours or smuggling items onto the ward and we do not understand how she could still be able to smuggle items into the ward as an inpatient. We appreciate that there are issues with **respecting patients'** dignity when carrying out searches but in light of her clearly increasing risk it is clear to us that there must have been a better way to search her when she came back from these periods of leave. The approach to searches seemed inconsistent.

14.6. It was never clear who was responsible for communicating Beth's risks on handovers while she was an inpatient, given the number of times she would self-harm despite being an inpatient. We had concerns that agency staff were often different and there was insufficient information and lack of communication on handovers.

14.7. We were never told about the two near misses on the 1st and 2nd January 2019. We only found out about these from the independent investigation. Not only were they not recorded as near misses on the medical records, but even EPUT's RCA report downplayed the significance of these incidents. It seems that following these incidents there was no further assessment of her risk by a psychiatrist – we think that this It is of concern to us that the Trust not only did not inform us about these incidents but did not even record these. The independent investigation was of the view that these incidents should have led to her being managed under the Mental Health Act under s2 or s3.

14.8. She was completely let down by the Trust when she disclosed the allegations of trafficking and exploitation. Clearly, there should have been appropriate management and safeguarding to limit her exploitation by men in light of the allegations she had made when was still an inpatient and restrictions on how she used leave.

14.9. She consistently raised concerns with exploitation both whilst an inpatient and when being managed in the community but these were treated as "sub plots" in her life rather than being taken seriously as a cause of her deteriorating mental health or forming part of a holistic treatment plan and should have been investigated more thoroughly. She raised these concerns a number of times and though it appears that staff believed her no concrete safeguarding actions were taken by them.

14.10. EPUT's own internal investigation concluded that there was a failure on the part of staff on the Peter Bruff Unit to submit the relevant safeguarding forms

following her disclosure to [I/S] about her ongoing exploitation on 12 December 2018, even though forms SET SAF 1 or 2 were completed These should have bene forwarded onto Essex County council or the Safeguarding team and her care coordinator [I/S] should have been notified.

14.11. We have been asked to comment on the level of observations in place when Beth was transferred from the Peter Bruff Unit to the Thorpe Ward in Basildon Hospital on 15 January, the day before her death. In essence, Beth was transferred without any handover, consultant to consultant discussion or any member of staff accompanying her, so that receiving staff had no clinical history of Beth when she was transferred. The lack of proper handover meant that Beth went from being on level 3 1:1 observations being in line of sight at all times at Peter Buff ward to level 2 observations, 4 observations per hour. Then, purely on the basis there had been no adverse incidents in 24 hours she was further downgraded to level 1 observations on 16 January, without any further risk assessment carried out by a consultant psychiatrist. Given the near misses and consistent attempts at self-harm in the weeks leading up to 16 January, with the last instance of self-harm being on 14 January, to have done this without input from a psychiatrist and preferably input from a team of people involved in her care, this was clearly inappropriate.

14.12. EPUT made two formal admissions in the inquest into Beth's death in relation this transfer, one of which explicitly mentions the failure to put Beth on the correct number of observations [Admissions Relating to Care on 15 and 16 January 2019 by EPUT, undated] :

1. *There was a failure to ensure a full handover between Peter Bruff Ward and Thorpe Ward on 15 January 2019. Staff on Thorpe Ward were unaware that Ms Lilley was going to be transferred to their ward from Peter Bruff Ward on 15 January 2019 and they had no clinical history for her when she arrived. Importantly, they were unaware that she was on level 3 observations (1:1 and within eyesight at all times) and that she had recently self-harmed. Peter Bruff Ward had sent an email to Thorpe Ward*

to provide this information, but it was not received (it is not known why). Ms Lilley was transferred to Thorpe Ward without a member of Trust staff accompanying her. This is a breach of Trust policy and meant that any additional information could not be handed over verbally. No attempts were made by Thorpe Ward to contact Peter Bruff War to obtain more ***information….There should have been a full handover of information from*** *Thorpe Ward to Peter Bruff Ward, which would have included information about Ms Lilley* ***'s presentation, history of self****-harm and her observation levels. Peter Bruff Ward should have confirmed that Thorpe Ward had received this information before physically transferring Ms Lilley. Given* ***the complexity of Ms Lilley's presentation, there shou****ld also have been a Consultant to Consultant discussion about her history, the current treatment plan and her ongoing risks. Ms Lilley should have been accompanied to Thorpe Ward by a member of staff from Peter Bruff Ward to ensure that she arrived safely (which she did in any event) and that Thorpe Ward had the information they needed. When Ms Lilley arrived on Thorpe Ward unexpectedly, the Trust would have expected the staff to call Pater Bruff Ward to obtain a full handover over the phone but this did not happen.*

2. *There was a failure to place Ms Lilley on the correct observation levels on 15 January 2019 and 16 January 2019. Ms Lilley was placed on level 2 observations (4 observations per hour at irregular intervals) when she arrived on Thorpe Ward. On the basis that Ms Lilley was on level 3 observations on Peter Bruff Ward and she had tied a ligature and self-harmed only the previous day, level 3 observations should have been maintained on Thorpe Ward on 15 January 2019…****Prior to Ms Lilley's*** *arrival, staff on Thorpe Ward should have familiarised themselves with her clinical history based on documentation sent to them by Peter Bruff Ward. When Ms Lilley arrived, they should have carried out a full risk assessment and placed her on the same observations on Thorpe Ward. This would be on the basis that she was a new patient with very recent incidents of serious self-harm. There is no evidence that a full risk assessment was carried out on 15 January 2019. Ms Lilley was stable and there were no*

adverse incidents during her first 24 hours on Thorpe Ward so it was appropriate to downgrade her observation levels. Level 3 observations are very intrusive and should not be continued for any longer than is necessary. However, the downgrade should have been from level 3 observations to level 2 rather than level 2 to level 1. A full risk assessment should also have been carried out and there should have been a team discussion, including a Consultant Psychiatrist, about the decision. The rationale for downgrading the observations should then have been accurately documented within the medical records

14.13. We have been asked about incidents during which Beth was kept under observation and whether we have any concerns about these incidents, or whether there were other instances where we feel she should have been kept under observation. We have set these out in our factual chronology above. Our general observation in relation to observations is that there seems to have been an inconsistent approach to determining observation levels after incidents of self-harm requiring a hospital admission and it was difficult to understand the rationale behind these incidents. For example, in the stay from 30 December 2018 to 3 January 2019, where there were the two near misses, Beth was initially kept on level 2 observations after being assessed by a consultant psychiatrist Dr **[I/S]** Despite a near miss on 1 January she remained on level 2 observations, without any further risk assessment by a psychiatrist. On 2 January, following another near miss, she was put on level 3 observations after an MDT. On 3 January however this was again reduced to level 2, again without any further risk assessment from a psychiatrist. The **notes said she presented "bright" in mood and utilised leave appropriately**. She was discharged into the care of our mother the same day.

14.14. We are not aware of incidents where Beth was physically restrained by staff.

15. Leave, Absconsion and AWOL patients

15.1. We have already discussed, in the context of safety and in the factual background, our concerns with the ease with which Beth could leave when

she was admitted as an inpatient, and the incidents where she was able to bring items to self-harm with and illegal substance onto the ward. There was an inconsistent approach to leave policies.

15.2. We are only aware of once incident where Beth formally requested long-term leave from her inpatient stay- **which was to attend our father's funeral in** November 2018. This is according to the medical notes. However, as set out in our factual background, she seems to have simply been discharged and in fact as we understand it had not agreed with the discharge.

15.3. In relation to smoke breaks particularly, in some wards patients would go with the nurse to smoke and then at the end she would them march all back in. However, when she was in the Lakes, we understand that you need to be formally granted a period of leave just to have a smoke. Given what it was widely known and documented that Behtany was using periods of leave to engage in self-destructive behaviours this was less than ideal.

15.4. We do not understand how, when Beth disclosed her exploitation and the fact that she was using periods of leave to meet up with men, this did not factor into any risk assessment to granting her leave. There should have been better communication between the ward and the police in relation to these incidents.

15.5. Mum was normally notified if Beth had a period of leave. Staff would not always wait to ensure that she would be picked up - sometimes Beth would just be waiting outside when our mum arrived, often unsupervised.

15.6. Both of us have picked Beth up multiple times from periods of leave. We never were told anything about her current mental health, any changes to risk or significant incidents or changes in mood.

16. Transfer

16.1. We have been asked to comment on the potential transfer to the Priory at Southampton, when she was returned due to a lack of beds. In truth, she was

there for such a short time that no one from the family visited her at the Priory. None of our immediate family live there, and she was only there for a day or two. We feel however that it would have been unsettling for Beth to have been subjected to a hospital transport for such a long journey only to be returned a day or two later.

16.2. We have also been asked to comment on the transfer between the Peter Bruff Ward and Thorpe Unit on 15 January 2019. We have set out in detail the issues with the transfer on this date in the factual background above.

17. Discharge and Continuity of Care and Treatment in the community

17.1. We have set out a timeline of Beth's various inpatient stays and discharges above. We have also set out our concerns about the fact that after her long stay at the Lakes in 2018, her treatment teams would set discharge dates in advance and stick to them, even where there had been no change to Beth's symptoms or an escalation of her symptoms.

17.2. Her inpatient stays were short term and did not seem to have any effect on her symptoms, with her self-harming and reporting suicidal thoughts soon after discharge and often attending an A & E soon after discharge, especially once our father died. Often the rationale for discharge was hard to follow as discharge summaries still referred to Beth having ongoing suicidal thoughts and being classed as high risk. [Medical Records, Discharge Summaries] By way of illustration:

i. She was discharged from the PBU on 3 January 2019 despite the two 'near misses' and the lack of any assessment of her status under the Mental Health Act. The discharge summary says she reports "continued suicidal ideation" and also that she said she was unsure why she was there as "nothing has changed since last admission/discharge." Her case notes say that she continued to be high risk.

ii. She was discharged from the PBU on 18 December 2018 where her discharge summary says she continued to experience suicidal thoughts, **that her symptoms had become "severe" and has used cocaine whilst on** leave during the inpatient stay.

iii. On 22nd November 2018 she was discharged from Thorpe Ward at Basildon Hospital, after having been detained under section 3 under the MHA on 15 November and after being transferred there from the PBU. She had to be re-admitted to Thorpe Ward on 24 November. According to her case notes , she was discharged without her medication and had not been referred to her Home First team. She reported not being happy that she had been discharged from Thorpe Ward as she did not feel ready for discharge and that she had expressed her concern for her suicidal ideation but was not taken seriously.

17.3. She was discharged from the Lakes on 13 August 2018 despite having **"chronic suicidal thoughts" and multiple recent attempts at self**-harm as detailed above in the factual summary. Her case notes also record that on 12th August ***"Staff member overheard Beth in the garden speaking to fellow*** *peers saying she would wait until she was discharged and then kill herself at home, and this information was passed on to the NiC of the shift to be handed* ***over to the morning shift."*** It is not clear that this information was acted on

17.4. Beth was managed in the community by the various teams including the Home Treatment Team, the Specialist Mental health and the carers form Reed Care services. Outside of our mum who would sometimes be at home when they attended ,we never met any of them. Behtany would tell us these could be quite informal, with no set times for their attendance.

17.5. We were not sure how her care in the community was supposed to be – but it all felt very unstructured and random what they would offer to meet up. Beth would say that she just had a chat with them so it did not feel particularly robust or structured in terms of therapeutic care.

18. Family engagement

18.1. We have discussed the extent to which our family was involved in Beth's are in the factual background above. In short, only our mum was involved in Beth's discharge planning and care plans and on those occasions where she attended meetings with Beth's treating teams, she rarely spoke or was acknowledged and always had the distinct impression that she was not wanted there.

18.2. We did not meet Beth's most recent care co-ordinator until she gave evidence at the inquest. She seemed to be out of the depth in the role that she was purportedly doing. Our impression was that there was little training and she was sort of making it up when as she went along. She was shockingly defensive and attempted many times to emphasise that Beth trusted her and told her everything, with suggested to us that she had no understanding of Beth's personality disorder.

18.3. She had a really good care coordinator for a good length of time initially and then it changed rapidly a couple of times. Our mum said that she got on well with the first one and she included her in everything relating to her care in the community, but the other ones hardly even said, 'Good morning.' She would just leave the room and let them get on with it. They wouldn't speak to her and when she went.

18.4. Beth was always discharged into our mum's care but we did not really feel that the Trust was doing enough to safeguard our mum. Our mum herself suffers from her own health issues and no support was afforded to her at all in managing Beth's presentation in those last weeks.

19. Concerns and complaints, quality, timeliness, openness and adequacy

19.1. We have set out our concerns about Ardleigh Ward at the Lakes above, stating that that is where we believe Beth came into contact with people who

were bad influence where there was a haphazard approach to observations and risk management, and that the ward always seemed understaffed and somewhat unsafe. Sarah, our oldest sibling, also reported anonymous concerns to CQC about The Lakes following Beth's reports of being able to find blades to self-harm, and the apparent ease with which she could obtain cocaine. Beth was not admitted to The Lakes again due to the ease in which she obtained cocaine. The family are aware there was an investigation about cocaine use in The Lakes whilst Beth was an inpatient that was reported in the local papers.

19.2. We note with concern that Paul Scott's evidence to the current inquiry (Witness statement bundle tab 3 PDF 23 re 2020) that a number of Health and Safety Executive ('HSE') prosecutions have been in relation to Ardleigh Ward at the Lakes, these prosecutions relate to incidents that happened before Beth's time on the ward This suggests that the issues with the ward were well known at the time of Beth's inpatient stays.

19.3. We have already set out issues with lack of communication above. We were rarely informed about changes to Beth's risk while she was an inpatient and were often not informed about serious attempts at self-harm. We did not even find out about the near misses where Beth came close to losing her life.

19.4. In terms of openness and adequacy, during the inquest into Beth's death that some of her notes which appeared to be contemporaneous were misleading. We heard evidence in relation to a retrospective entry by an agency Nurse named [I/S] made on the night of Beth's death, where the nurse was asked to come back to work to record an observation of Beth write before her death. HM Coroner asked the Trust where there was there a chance, in light of this retrospective entry that she wasn't observed at all, and the Trust had to concede that this was a possibility. This was raised in EPUT report which minimised it.

19.5. We have discussed receiving the DATIX reporting spreadsheet half-way through the inquest, which we have exhibited to this statement. It is of concern to us that every incident of self-harm by Beth, most of which resulted in an A & E attendance, was classed as either 'low harm' or 'no harm'. In our families case, there was a systematic underreporting of ligature risk on DATIX.

19.6. Beth died on the 16th of January 2019. Our mum was informed what we felt was quite a callous way. She had not heard from Beth all day and kept ringing her phone to no response. She had been concerned about her in light of the multiple suicide attempts. Finally she called Thorpe ward at 8.30 PM and was informed everyone was in a ' handover meeting' and someone would call her back.

19.7. She was called by a doctor and given quite a graphic blow by blow account of how Beth was found and the resuscitation attempt without being told at the outset that she had died, so that she had to interrupt the person who called her and ask "is she dead". She was also informed that staff had tried to contact her earlier but Behtany's medical notes had incorrect contact details for her.

19.8. Mum and our sister Joanne went on 17th of January 2019 to collect her things and on this occasion had a short unexpected meeting with staff from Thorpe Ward.

20. Quality of Investigation

20.1. It was only at the end of January 2019 that we were told that there would be an internal investigation by EPUT and a Family Laison Officer would be appointed. We had no further contact from the Trust for four months. It was only as a result of extensive advocacy by Sarah that we received any information whatsoever.

20.2. On 26 March 2019 we were asked to submit a 'Life Letter' to the Coroner and we used this opportunity to complain about the complete lack of

communication from EPUT about the investigation. We said that *"the family have not been kept up to date on the Serious Incident Investigation. Beyond the initial meeting with Julia and Joanne when they collected Beth's belongings, and a letter providing contact details of a Family Liaison Officer at EPUT, who has contacted Julia once, no further information or timeline about the Serious Incident has been shared."* [Life Letter from Sarah Guille (on behalf of Julia Guille) to HM Coroner's Office dated 25 March 2019]

20.3. On 3 April 2019 we were finally contacted by [I/S], a new FLO, who gave us the first update about the serious investigation report and told us that there would be a meeting in due course with ourselves and the investigators.

20.4. We are now aware that this investigation started after the Trust began being investigated by the HSE, something which does give us concern.

20.5. On 16 April 2019 our sister Sarah emailed the EPUT investigator [I/S] requesting initial meeting set for 1st May. [I/S] responded that he was unsure if he could arrange medical representation for this meeting. Sarah advised [I/S] that as this is two weeks' notice the family expect this is sufficient time to arrange medical representation. In addition we would expect the interim findings to be shared at the meeting.

20.6. On 23rd April 2019 we were contacted by [I/S] who said medical representation could not be secured in time for a meeting on 1st May 2019. Our sister Sarah emailed [I/S] Interim Deputy Director of Nursing, to say that she felt unsupported by the medical team. [I/S] responded that an alternative consultant psychiatrist would be secured for the meeting though

20.7. On 24th April 2019 Sarah received an email from [I/S] from NHS England and Improvement advising that an Independent Investigation would be opened into Beth's death. The investigators appointed: Duncan and Johnstone. This is the independent investigation referred to throughout this statement. The email also offered a meeting with Duncan and Johnstone. On

29th April 2019 Duncan and Johnstone followed up offering a meeting on 30 May 2019.

20.8. On 1st May 2019 the first meeting with EPUT took place. Sarah had to email beforehand to find out who would be at this meeting. The meeting was attended by our FLO [I/S] [I/S] the lead internal investigator, Dr [I/S] the locum consultant psychiatrist, [I/S] a service manager and the clinical director Dr [I/S]. They provided an overview of the Serious incident review process and it was re-assuring to know this was being investigated. We were also provided with a provisional date for the report which was 20 May however were advised it was highly likely that this would be extended.

20.9. On 30th May 2019 we had our initial meeting with the independent investigators.

20.10. On 10 June 2019 EPUT advised that their internal investigation will be delayed and the outcome should be available to us at the end of July. On 19 July 2019 we had a further meeting with the independent investigators Johnstone and Duncan to approve the chronology of Beth's **treatment as set** out in the report. [I/S] from the Mid-Essex Clinical Commissioning Group (CCG) who commissioned the investigation

20.11. On 22 July 2019 and 1 August 2019 we sent chasers to EPUT after not having heard any updates regarding the Serious Investigation Report. In response to the latter email we were provided with a draft copy of the investigation report. We noted that there were typographical errors throughout this version of the report. There also was an observation made in this version of the report **that 'it is worthy of noting' that an anchor point was not used. The** tone of this comment was self-congratulatory and made us feel that the

incident was considered as less serious than if an anchor point had been used.

20.12. **[I/S]**, Interim Deputy Director of Nursing for EPUT contacted us to advise that the Toxicology report showed no evidence of alcohol or illicit drugs on 12 August 2019. On 27 August 2019 our mum asked Sarah to email the EPUT investigators to specifically address the way that she was told about Beth's death.

20.13. We received the final version of the EPUT Serious Investigation Report on 5 September 2019. On 20 March 2020 we met with the independent investigator to receive the outcome of that report.

20.14. We felt that the independent report by Duncan and Johnstone was more robust than the internal investigation. EPUT wrote one letter in response and that drew a line under it – not effective procedure to tackle such a case.

20.15. The response letter to the independent investigation by EPUT was also defensive and confrontational. [Factual accuracy response by Dr Milind Karale dated 24 January 2020]. The response letter disagreed with the independent reports suggestion that Beth was likely suffering with co-morbidities and accused the independent investigators of going beyond the scope of the report in commenting on the diagnosis of EUPD, and the lack of a robust diagnostic framework,. It disagreed that Beth had substance abuse problems and said that there is no evidence from the records that this was a primary issue. It stated that though there were issues with the PARIS and the MOBIUS data management systems ***"talking to each other"*** most of Beth's treatment notes were on PARIS. In relation to the concerns about overmedication, Dr Karale made a sarcastic comment to the effect of clearly the blood pressure medication was needed, which we felt was unnecessary given that clearly the report was talking about psychiatric medication. Finally Dr Karale criticised the independent report's authors for mentioning various

CQC inspections and the corporate manslaughter investigation saying that this went beyond the scope of the report.

20.16. We have significant concerns that EPUT were not open to responding to negative feedback. It is not clear to us in view of the negative initial report, the poor learning lessons report and the defensiveness in the inquest that EPUT has embedded changes. Accountability requires meaningful changes to practice and approach. We have yet to see this, including from witnesses to this Inquiry.

20.17. We highlighted our concerns regarding the EPUT reports findings and the factual accuracy response in our letter to Duncan and Johnstone dated 6 April 2020. We have referred to these throughout this statement but in summary these were:

i. The downplaying of the two near miss incidents even in the EPUT serious investigation report, the significance of which we do not appreciate until the independent report
ii. The insistence that the medication regime was adequate and that Beth was not an addict
iii. The defensiveness about the diagnosis and the insistence that it was obvious to her treating clinicians what her diagnosis was.
iv. The lack of a formal EUPD pathway

20.18. On 24 August 2020 we had a meeting with [I/S], the chief nurse at the Clinical Commissioning Group for Thurrock who presented **'Lessons Learned' document from EPUT as 'System Response'**. We found everything about this presentation shocking – **the 'report' was a landscape** PowerPoint presentation which was presented to us in hard copy. We were told that we were not going to be talked through it line by line so we had to go back to read it and write back on 1st September 2020 with our comments which we repeated in our letter to the Coroner on 14 October 2020 [Family

submissions to [I/S] Thurrock CCG dated 1st September 2020, Letter to Coroner by family dated 14 October 2020]

20.19. In short our view was that the lessons learned document was not fit for purpose.

20.20. "The 'lessons' identified in the report were four short statements crammed on to one page. It is offensive in the highest degree to suggest that only four lessons are to be learned from our sister's death, which can be summarised onto one page, none of which outlines the failures identified by the Serious Incident Report in the last few days of Beth's life . Indeed, the lessons learned report drew entirely on the findings of the independent report and ignored entirely the Serious Incident report.

20.21. Much of this landscape PowerPoint presentation was taken up to what was called the "pathway diagram" A sort of flowchart which included a loose chronology of Beth's care, had no explanation and left us utterly confused. When we queried this by the latter dated 1 September 2020, o in their reply letter dated 25 September 2020 we were told this is hypothetical and illustrative of the intentions of the ongoing workstream to introduce a pathway for EUPD. Rather than assure us, this has left us feeling that this is simply an attempt to placate us, and we fail to understand how this diagram will mean anything to anyone outside of the family, or how it shows any 'lessons learned' to be applied elsewhere.

20.22. The initial version of the report shown to us had numerous spelling errors which were later corrected. We raise this only because we had been told that it had been signed off by numerous senior people at EPUT. We did not see any signatures or names of these people on the report.

20.23. The response on behalf of the CCG in regard to how the report ensures system wide learning was that EPUT covers the whole of Essex, therefore this report is by nature systemwide.is If there are no other organisations

within the System, how can any report be used to challenge practices and make changes, when it is written by the organisation who failed in the first place.

21. Other investigations or legal proceedings

21.1. The inquest into Beth's death took place between 28 February and 17 March 2022. A copy of the record of inquest is exhibited to this statement. [Record of Inquest dated 17 March 2022]

21.2. We have quoted the two formal admissions EPUT made prior to the inquest above, but in summary these were:

i. There was a failure to ensure a full handover between Peter Bruff Ward and Thorpe Ward on 15 January 2019
ii. There was a failure to place Ms Lilley on the correct observation levels on 15 January 2019 and 16 January 2019

21.3. The above admissions were included in the narrative conclusion.

21.4. The jury returned a finding of neglect in the inquest, after over two weeks of hearing evidence from the clinicians involved in Beth's care. As we have come to appreciate, this is an exceptional finding requiring a jury to be satisfied that the failures in care admitted to "gross failures".

21.5. The jury found made the following findings regarding failures that more than minimally contributed to Beth's death

i) There was a failure in the diagnostic formulation process
ii) Lack of adequate documentation record keeping by EPUT (inadequate care plan, inadequate discharge summaries, failure to complete risk assessments, incomplete level 1 observation sheets on 16 January, inadequate monitoring of leave on 16 January, inability to access all patient record systems)
iii) Further risk assessment and risk plan were not undertaken between 11 January 2019 and BL's death.

iv) The use of different record keeping systems (Paris and Mobius) meant that staff on Thorpe Ward could not access her history.

21.6. The Jury also found that lack of record keeping, risk assessments, lack of proper handover to Thorpe Ward and failure to keep Beth on correct **observations were all "gross failings."**

21.7. Finally, the jury find that the proposed discharge date for Beth on 22 January was inappropriate and that observations were not carried out properly on 16 January.

21.8. **[I/S]** There also did not appear on our part to have been a huge amount of preparedness on the part of the Trust in the inquest. There were huge issues with disclosure, with a failure to disclose documents until the last few weeks leading up to the inquest, with significant documents even disclosed during the course of the inquest, for which they were criticised by the Coroner.

21.9. By way of illustration, when giving evidence, one of the treating psychiatrists, Dr **[I/S]** produced and referred to a document **she** had brought with **her** in a folder which had not been previously disclosed, for which **she** was reprimanded.

21.10. We therefore find it surprising to hear the evidence of Ann Sheridan in the current enquiry who has stated

" EPUT takes the responses and actions arising from PFDs, findings of neglect and inquests very seriously. This is reflected in the governance processes which EPUT has in place to deal with PFD reports and any related ROIs, and this includes processes where the Trust disseminates information, learning points and actions arising from PFD findings or inquest findings with adverse outcomes. We have been able to establish that in SEPT from 2014, ***a member of the Trust's Inquest Team attended hearings****. For EPUT (2017), dedicated Inquest Officers represented the Trust, provided ad-hoc information to the Court and supported witnesses. The Inquest Officers were appointed based on the knowledge, skills and experience required for the role and recruited to support the process based on their career backgrounds. On-*

the job training and support were provided, and since May 2023, the Inquest Team had expanded and currently operates with the addition of two trained solicitors. Following the hearing, Inquest Officers provided witnesses and court attendees with a de-brief; and this included sharing of the conclusion and learning for the individual and wide organisation. The conclusion and learning identified was communicated to the Head of Patient Safety Incident Management for escalation and inclusion in reporting processes."

21.11. EPUT settled a civil claim by the family prior to the inquest.

Part 3

22. Recommendations and lessons to be learned

22.1. At this early stage of the Inquiry we are not in a position to propose final recommendations that we would invite the Chair to make as we have not considered all the evidence and the Inquiry has not completed its investigations. However, to assist ILT and the Chair we have set out below some key areas of concern for our family for the formulation of recommendations for change.

22.2. As we have said above, the lack of a robust diagnostic framework for EUPD **and an approach which emphasised treating Beth's symptoms rather than her** underlying issues was what we think the underlying cause was behind the failure in all her clinical interventions. We urge the Trust to take steps to establishing a robust pathway for the treatment of EUPD.

22.3. There is also a need for good support services both for sufferers of EUPD and their carers. The Haven Project which provided such support for people with personality disorders was a valuable resource **[I/S]** but funding has been so cut for it in recent years that the support Beth got from it was minimal.

22.4. We have spoken at length about the closed culture at the Trust when it came to keeping us informed about changes to Beth's risks while she was an inpatient. As we have described above, we only learned of the two near misses after Beth's death, and would frequently not be informed at all when Beth had to be taken to an A & E due to an attempt at self-harm. It was never communicated to us how her risk would be managed, with the approach to observations seeming haphazard and random to us. We would welcome more open communication between staff and family members, and a change to a culture which either downplays change to risk or does not communicate risk at all.

22.5. On this note, there should be mandatory reporting of all near misses and the family must be informed in every instance where there is a near miss.

22.6. We would push for greater involvement of the family in discharge and care planning. As we have mentioned our mum would sometimes be invited to meetings but her input would rarely be sought and she always had the impression that she was not really welcome. Where there is a requirement to involve families, this must be more than lip service. Where there is a plan to discharge a patient into the care of a family member or carer, there also should be adequate support provided to the carer and a safeguarding assessment.

22.7. When transferring between wards staff ensure that a full handover takes place and that receiving staff are aware of all relevant background of the patient being transferred. There should be minimum standards as to what any handover should involve. In Beth's case, in the crucial handover between the Peter Bruff Unit and Thorpe Ward on 15th January 2019, Peter Bruff Unit staff attempted to handover by telephone. When this wasn't answered staff did not think to make any follow up attempts.

22.8. We are concerned that Beth's risk was systematically underreported on DATIX, and by the evidence at the inquest that observations were post-dated and completed after the fact. Families need to be able to be confident that the

institutions to which they are entrusting their loved ones are record keeping accurately and not actively underreporting or entirely covering up adverse incidents.

22.9. The defensive culture which we experienced after the death of our sister is something no family should have to endure after facing a bereavement. From the stand-offish and defensive response of the Trust to the independent report, to the defensive attitude of the witnesses at the inquest to the late disclosure half way through the inquest process of key documents, it felt like our search for answers was being frustrated at every turn. It fell to us, for example, to chase for updates about the Serious Investigation Report, and it took complaining to the Coroner to even get a first phone call from our Family Liaison Officer. The Trust must learn to deal with bereaved families with compassion and openness.

22.10. We support the submissions of INQUEST that there should be a national oversight mechanism which is independent and can properly scrutinise the implementation of recommendations.

22.11. A key issue in the transfer between the Peter Bruff Unit and Basildon Hospital on 15/16 January 2019 was the fact that information about our sister was held on two different computer systems and staff from the receiving unit could not access her records from the unit from where she was being transferred. Needless to say, this should not have happened, whilst we understand that changes are being implemented these were plainly too slow and there should be careful consideration of how information sharing functions. All staff should be able to access all information about any patient.

22.12. An issue also was that staff were not trained in the Healthcare Information Exchange system which allowed them to access data from the other system. All staff should be fully trained before being deployed on the ward.

22.13. We hope that these preliminary observations are of assistance to the Chair at this stage and we are available to provide any further information as needed

Statement of truth

We believe that the facts stated in this witness statement are true. We understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth

Alex Guille **Signed** Alexander Guille

Dated 03/06/2025

Paul Guille **Signed** Paul Guille

Dated 03/06/2025