Witness Statement of: **Docas Nsilu**
No. of statement: **1**
Exhibits: **0**
Date of statement: **24 June 2025**

LAMPARD INQUIRY

WITNESS STATEMENT OF DOCAS NSILU

I, Docas Nsilu **[I/S]**, of **[I/S]**, will say as follows:

1. This statement attempts to address the rule 9 questions from the Inquiry provided to my family. My parents do not feel able to provide a statement for the Inquiry as they would find it distressing to go over everything that happened to Edwige again, haven already provided several accounts during the inquest process. I will answer the Inquiry's questions to the best of my knowledge. However I am not able to answer most questions from my own direct experience or recollection, as they largely relate events that I did not witness. I have attempted to address most of the questions by outlining the relevant evidence to that question within my knowledge and explaining my concerns arising from this.

2. Most questions are answered in respect of Edwige's time at St Andrew's Essex. This is because most of the evidence I have heard has related to her time at St Andrew's. I do not know enough about Edwige's time at other hospitals before St Andrews to be able to answer the Inquiry's questions on this period, with the exception of a few questions relating to Edwige's time at Oaktree Manor, which was covered in the Safeguarding Adults Review which was conducted before the inquest.

3. This witness statement has been prepared by my solicitor following remote consultations with me. In preparing his witness statement, it was necessary for my solicitor to remind me of details from the relevant evidence at Edwige's inquest and from the other investigations that took place following her death, before I could address the Inquiry's rule 9 questions. All of this is summarised in this witness statement, to give the Inquiry a full picture of what I understand happened and why, and my views on this.

4. I have only addressed the rule 9 questions which I feel am able to answer from my knowledge of the evidence about what happened to Edwige arising from her inquest and the investigations into her death. There are some questions I do not feel able to answer

Background

5. Edwige is my older sister. My mum and dad have seven children together, and Edwige and I were the closest in age. We have two older brothers, and also two brothers and one sister younger who are much younger. Our parents are from the Democratic Republic of Congo and their native language is Lingala, which is a dialect of French. Myself and my siblings were all raised to speak Lingala with our parents at home.

6. Growing up, I was like the little annoying sister to Edwige who used to follow her around everywhere. I used to try and get in with her group of friends. We used to play together a lot. Me, her and my older brother used to call ourselves the three musketeers.

7. I am currently training to become a nurse. I am at university and I also have placements working in adult nursing at Northwick Park Hospital.

Diagnosis

When did Edwige first become unwell? In what way did any mental health difficulties first develop or become apparent?
What were the circumstances that led to that first contact with mental health services?
How did matters progress from there? Over what period?

8. I did not know anything about how Edwige became unwell until after she died. Edwige was taken from our family by social services when we lived in Hertfordshire in October 2014. I was only 13 at the time. After she was taken away by social services in Hertfordshire, our contact with her was very limited. Social services who had taken her never told us she had become mentally unwell, and neither did Edwige whenever we were allowed to see her. It was only after she died that we even learned she had been suffering with serious mental health problems. I now understand more about what was going on with her after, but none of our family had any idea she was unwell at the time.

9. I refer to paragraphs 13 to 26 of inquest witness statement from my mum which explains our family's perspective of what happened to Edwige from before and after she was taken away by social services, until she arrived at St Andrews. My mum was the main point of contact from our

family for social services and Edwige while she was away, so I consider her account of this period would be most useful to the Inquiry.

10. My mum says this in her statement:

> *13. Edwige began to present difficulties in early 2014 while we were living in Walthamstow. Her school informed me she was bunking off, and after I tried to raise this with her she returned home with some police officers police officers who explained she had alleged that I hit her all the time. She went to stay with a family friend for a short period while these allegations were investigated by social services, but ultimately Edwige was returned home as they found no evidence that she was being abused. Shortly after this we moved as a family to Hatfield in Hertfordshire.*
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> *14. In October 2014 Edwige ran away from home. My husband and I reported her missing to the police, and she was returned home that night with police officers. However, she managed to run away again that night, which we again reported and the police returned with her at around 10pm. Edwige had told the police that she didn't want to live in the house with us anymore, and they said they would have to report this to social services.*
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> *15. Edwige went to school the next day. At around 11am in the morning, her school contacted me to report that Edwige had stated she was a drug dealer and that she was keeping drugs in her bra. They said they couldn't search her bra and so had called the police to search her. Then at around 1pm, Edwige was returned home with the police officers, who said they had found powder in her bra but that they could not confirm if it was drugs or not. It looked to me as though it was a type of powder that we use to cook with at home.*
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> *16. Edwige was excluded from school for 2 weeks. Following this incident, I was visited by two social workers who told me that Edwige had alleged we were always hitting and beating her. They found marks on her arm and when they asked her where these had come from she said they had come from her dad beating her with his belt. However one of the social workers said they believed the mark was self-inflicted.*
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> *17. That night I went to Edwige's bedroom and saw she was shaking, so I called an ambulance. At the time I had a young baby and two children under 5 who I could not leave alone, so my friend accompanied Edwige in the ambulance. The police then contacted me to tell me that Edwige had taken her sister's antibiotics and that they needed to investigate what was wrong.*

18. *At around 7am the following morning I went to see Edwige in hospital. When I got there social services said I was not allowed to come in. They called a mental health doctor to establish why she was acting this way, but they concluded that she did not have any mental health issues and so Edwige was eventually returned home.*

19. *On Monday 27 October 2014 social services came to our house. They arrived in the morning without an appointment. When I opened the door, they said they were there to see Edwige. Edwige and her sister Docas were visiting my sister in Birmingham for the week and I told them this. They said they didn't believe me and accused me of hiding her. They told me to open the door as they needed to see her now. They searched everywhere in my house and garden for her. I gave them my sister's number and when they contacted her, she confirmed Edwige was in Birmingham with her. Social services told my sister to return with Edwige immediately. I gave my sister money to travel and she was able to get Edwige on an express train back to London. Social services remained at my house until Edwige arrived. When Edwige returned she was upset and confused about having been called back. She went upstairs to her room. One of the social workers followed her while the other one stayed with me in the living room. My other daughter, Docas, later informed me that she had overheard the social worker in Edwige's room encouraging her to leave the house and to wait around the corner so they could pick her up.*

20. *After the social workers left, Edwige asked to go back to Birmingham. My sister told her no, that she had to stay here. Edwige went upstairs and I went to prepare dinner. When it was ready I asked Docas to call Edwige from her room. Docas came back down and told me that Edwige was not in the bedroom. I went upstairs to check and realised Edwige had ran away again. I called the police to report Edwige missing but when the police called me back they informed me that Edwige was with social services.*

21. *In the morning, me and my husband went to the social services office where we were told that we needed to sign paperwork acknowledging Edwige had been removed from our care. I started to cry and refused to sign any paperwork as we had not done anything wrong. I was told I did not have the right to know my daughter's location and that if I refused to sign the paperwork I would be sued or sent to court.*

22. *We both continued to refuse to sign the paperwork relinquishing our custody of Edwige. As a result, our other children who lived us with were placed under safeguarding measures. We hired a solicitor to help win back custody of Edwige. When we went to Court we did not see Edwige, only her solicitor, who stated that Edwige had said she would kill herself if she had to return home. The judge stated there was nothing he could*

do about this, and that in this kind of situation Edwige needed to be placed somewhere else. He placed Edwige into foster care.

23. *Edwige was placed in foster care but she was moved after setting the foster carers' house on fire. Social services then transferred Edwige to a residence in Luton that housed several other teenagers. Edwige was not attending school so I asked social services about their plans for her education. They told me they were still trying to register Edwige to go to school in Luton. I was later informed that Edwige had run away from Luton but the police had found and returned her.*

24. *Social services then contacted me to let me know they had decided to move Edwige to a "secure unit" in Liverpool. I objected to this because the unit was miles away from where we lived. Social services told me that it had already been decided but not to worry because they would cover our petrol and accommodation costs if we wanted to visit. We were given the address after Edwige's transfer, so we travelled as a family to Liverpool to see her. At Edwige's new accommodation, all the doors had locks and visitors could not bring mobile phones into the building. I was surprised and upset that it seemed just like a prison. I called social services and asked why Edwige needed to stay in this kind of facility. They said Edwige's repeated attempts to run away meant that this was the best place for her.*

25. *After several months Edwige was transferred to another place where she stayed for a week or two. I do not know the name of this place and never visited because Edwige called me and said there was no need for us to come and visit her as she would come and visit us. However, social services then told me she was not allowed to visit us because of how we had treated her. They told me it would be better if we met her in Westfield. At the time we were living in Hatfield which was nowhere near Westfield. When I told them I could not afford to travel to Westfield, they cancelled the appointment.*

26. *Two days later, social services called and told me that Edwige was not doing well. They told me she was acting aggressively, was fighting all the time and had beaten up someone up, so they would be moving her to another secure unit in Norwich. I asked how long she would be staying there but they said they did not know. They did not tell us that this was actually a mental health hospital or that Edwige was mentally ill or suffering mentally. I assumed she was there because she had beaten someone up and was running away. When I spoke to Edwige at the time she was crying a lot. She said she was not feeling well and she wanted to come home.*

27. *Our whole family went to visit Edwige at the secure unit in Norwich. I immediately noticed that she looked very unwell. She had gained a lot of weight and was acting strangely. She was spaced out, so when you talked to her it was like she was not really listening. She was also in chains, so I had to remove a chain from her for her to walk. We asked the people supervising Edwige who they were and they told us they were Edwige's carers. They were wearing civilian clothes, so I did not think they were medical staff. I asked them why my daughter was there. They said they could not say much and that I needed to speak to the person responsible for her care. I asked if they could find me that person, but they said they were too busy to see us.*

28. *When we came home I continually rang the secure unit in Norwich to find out what the situation was but I never received an answer. I never received any formal information or paperwork about Edwige's move. I felt that there was nothing I could do, and that I did not have a right or the ability to get involved.*

29. *Edwige remained at the unit in Norwich for a year and a half. Edwige was calling us herself during this period, but we did not receive any updates from social services which meant Edwige was our only source of information. When I asked her what medication she was taking she would say they were only giving her sleeping tablets and vitamins. I asked social services if they could provide petrol money for us to visit her, but they refused, saying they didn't need to provide this as Norwich was next to London. We used to use our own expenses. Edwige would ask us to bring food, so we were doing from our own expenses.*

30. *After the secure unit in Norwich, Edwige was transferred to a secure unit in Colchester. By this point we had stopped receiving any contact from social services, and so our only source of information was Edwige who told us this herself. While she was at Colchester we received no contact from the unit. Flavien and I believed the secure unit had been instructed by social services not to give us any information.*

11. This is also how I remember things. Although my mum was the main point of contact, our whole family were following these updates as we were all worried about Edwige and wanted to see her return home as soon as possible.

12. Looking back, I think her mental health problems must have started when we were living in Walthamstow in early 2014. I remember my teacher at school saying she had run away and that they needed my phone for information about what had happened. I remember social services started to come round to our house after this. I remember them taking her in for a while and then

she came home to live with us again. It was after this that my mum thought we needed a fresh start and so we moved to Hertfordshire. Now I think the bunking off school was the start of her becoming unwell, but I was not aware of this at the time.

13. I remember when me and Edwige were in Birmingham together, when we were told we had to come back home as social services were worried she would run away. We had to get on a coach the next day and come home. Edwige was stressing out and saying she wanted these social workers to leave her alone. We returned home and social services came back to the house again. I remember when they came inside the house, they went onto the small living room of our house and they told my mum to leave the room. I was outside the door. I remember hearing the social workers tell her to run away, which is what she did. My mum was worried and she called the police. The police told us Edwige was with the social workers. After this, Edwige came back home to get her stuff. I asked her where she was going. She said I'll be back. She told me not to worry and to be strong and to look after our younger siblings. I didn't understand. I was only little and was quite oblivious to what was going on. That was the last time I saw her before she was taken away.

14. When I found out that they were taking her away it made me feel sad. I didn't know what I was supposed to do now. I used to follow her in everything. I thought, how am I supposed to go to college, as I would have followed her. Without her I was stuck. I had to learn how to do everything on my own. It was very hard on me. I never knew my next step. I had previously always known that where ever she was, I was going to be. I felt heartbroken. I did not have social media and she did not have her old phone number anymore. I just felt on my own.

15. After Edwige was taken away, we were never told anything by social services about her becoming unwell, suffering from a mental health condition or being detained for her own safety in any mental health hospital. It was only after she died that we learned details of what was happening with her during this period through the legal processes which followed.

16. When social services allowed us to visit Edwige as a family, we did not know what to expect. We were shocked to see she was in a place with tight security. I remember we would have to go through so many locked doors. We did not know why this was and I just thought this was for safety reasons.

17. Before seeing her I was scared our bond would be broken. I didn't want to say the wrong thing to her and make her upset, because it looked as though she might have changed a bit. But when we saw her she made us feel comfortable. She had the biggest smile and warmth and the awkwardness faded away when we talked. We talked about her trips, music and songs, church,

old friends and catching up. She made us feel better. She seemed fine to me when we saw her so we had no idea of what was really going on.

18. Our visits with her were like that until she ended up in St Andrews. We would always all visit her together as a family. She would always have presents waiting for our younger siblings who were still young children. She would be saying that she would be coming home soon. We would always meet her at shopping centres. One time we went bowling together and she used to love going to Nandos. She always made sure we were having fun together.

19. Most contact with Edwige was through my parents, but there were sometimes when we would speak to each other independently on the phone. I remember there was a time when she told me about her breakup with someone. I think I told her men are trash and advised her to move on or something. We used to have a few one to ones together, where we would give each other advice about normal things like dating.

20. I am now aware that social services stopped being responsible for her after she turned 18 but we didn't ever receive any update of this from them and we continued to believe they were the ones responsible for her while she was at St Andrews.

21. I am now aware that Edwige had a diagnosis of Emotionally Unstable Personality Disorder and Complex PTSD, but my family only learned this after she passed away as a result of the inquest process. I am not aware of when she was first given these diagnoses. My solicitor informs me that the records we have from the inquest include forms relating to her being sectioned under the Mental Health Act 1983 in April 2016 which refer to her having these conditions. However this is not something I have any knowledge of beyond this, so there is nothing more I can say about her diagnoses.

22. Our biggest concern as a family about this whole period from 2014 until she arrived at St Andrews is that we were given no information at all from Hertfordshire Social Services or from any hospital about what was happening to Edwige. We had no idea she had a serious mental health condition and she was being detained for this for such a long time. We were left completely in the dark about this. This long period of exclusion caused harm to us and I have no doubt it would have been also been damaging for Edwige. She was just a teenager during this period. Five years is a very long time for a young person to feel isolated from her family. Every time we saw her she was acting as though everything was fine, but we now know it wasn't. We could have supported her but we weren't able to. She was left to struggle on her own without the support of the people who loved her the most. I hope the Inquiry recognises the damage that this caused on both sides.

Assessment and admissions

Please could you tell us about any mental health assessment for Edwige which took place during the relevant period in relation to her admission for to an inpatient unit. This includes Edwige's admission to Colne Ward. For each assessment could you provide the following information:

a. *When did it take place?*
b. *What circumstances had led to it?*
c. *Was it a routine assessment as part of ongoing care and treatment in the community, or an emergency/crisis assessment, for example at home or in Accident & Emergency?*
d. *By whom was the assessment carried out?*
e. *Were you and/or any other family members or friends present during the assessment?*
f. *What matters were covered during the assessment?*
g. *What information was sought or taken into account by those carrying out the assessment?*
h. *What was the result?*
i. *What were the next steps following the assessment to be, as far as you are aware?*
j. *Did any planned follow-up steps occur? If not:*
    a. *Why was that?*
    b. *Were alternative plans made? If so, please describe those.*

Do you have any observations, comments or concerns regarding the quality, adequacy, process or outcome of any such assessment?

For each admission and inpatient stay please could you tell us:

1. *What were the circumstances of the admission? What had led up to Edwige being admitted?*
2. *By whom was the decision to admit made?*
3. *Was the admission made under section (i.e. under the Mental Health Act 1983)?*
4. *When was the decision to admit Edwige made?*
5. *When was she actually admitted? Was there any delay in this taking place?*
6. *To which hospital/unit/ward was she admitted?*
7. *How long did Edwige stay there for?*
8. *Is there anything that you want to share about how her mental or physical health developed or changed over that period, or any other changes more generally, such as in Edwige's demeanour?*

Do you have any information or observations you wish to share about the admission process itself on any of the occasions that Edwige was admitted or about any aspect of the way in which admission was handled?

In your application for core participant status, you have explained that Edwige was detained under the Mental Health Act from the age of 16. Do you have any information or observations you wish to share about the decisions made to detain Edwige under section or about any aspect of that process?

23. I don't feel able to answer any questions about mental health assessments and admissions of Edwige. All we knew about these assessments and admissions at the time was whenever Edwige told us herself that she had moved from one place to another, as outlined in my mum's inquest statement. She would whenever she had some important news, maybe around monthly. She would call my mum's number herself on a private number. We knew she spent a while at a place in Norwich and then moved to a place in Colchester, before moving to St Andrews in Basildon, Essex.

24. I now know from the chronology provided in the SAR that she was first admitted to Huntercombe Hospital on 6 April 2016, which was a secure unit for adolescents. Although this was initially intended as a short term admission, ultimately Edwige remained detained under the Mental Health Act 1983 until she died on 5 February 2020. She remained at Huntercombe Hospital until 21 November 2017. She then moved for a short period to Helleson Hospital, before then moving to Oaktree Manor in Colchester on 8 March 2018, where she stayed until her move to St Andrews on 8 April 2019. However we as Edwige's family did not even know these places were mental health hospitals at the time, or that Edwige was not allowed to leave them, as stated above. There were never any professionals from Social Services or the hospitals informing us of the details of each move.

25. When Edwige moved from Oaktree Manor to St Andrews, we were not contacted by any of the hospitals or St Andrees to explain the move. All we knew about the move was what Edwige told us. She told my mum she had been doing fine at the place in Colchester and that they were going to find her an apartment or something so she would have the freedom to come back home whenever she wants, but they were not able to find anything for her and so they were going to send her to St Andrews in Basildon where she could stay for a while she looked for apartments. She said St Andrews was the next step towards her coming home. When my mum was later contacted by a social worker at St Andrews **[I/S]** about Edwige having home visits again, nothing he was said seemed to contradict what Edwige had been saying, so this remained our understanding of Edwige's situation while she was at St Andrews.

26. I understand my solicitors have some records from Edwige's inquest which give details about the assessments leading to Edwige's transfers between hospitals, but I am not aware of the details and I so am not able to answer questions about these in this statement.

Oaktree Manor

Concerning any mental health diagnosis Edwige received:

- *a. What treatment, if any, was offered at the time of diagnosis?*
- *b. By whom was that treatment offered? Where was it to take place?*
- *c. Did she undergo that treatment?*
  - *a. If not, why was that?*
  - *b. If so, over what period did she receive that treatment?*
- *d. Where was that treatment (for example, in the community, or in a particular unit)?*
- *e. Were there any changes to Edwige's diagnosis over the relevant period? If so, please provide details of those changes.*
- *f. Were there any changes to Edwige's treatment, over the relevant period? If so, please provide details of those changes.*

Do you have any observations, comments or concerns relating to Edwige's initial or later diagnosis or treatment, or in relation to any lack of or failure to provide a diagnosis?

Do you think that decisions about Edwige's mental health treatment were made adequately and appropriately? If not, what aspects of decisions about her treatment do you think were not appropriate or adequate and in what way?

What therapeutic care was available for Edwige (either one-to-one or in a group setting)?

Do you think that the mental health treatment actually provided to her was adequate and appropriate? If not, being as specific as you can, in what way (and in relation to what specific aspects of treatment) do you think that her treatment was inappropriate and/or inadequate?

We understand from the Opening Statement submitted by your legal representatives that in July 2022, two years after Edwige's death, you learned that she had been assaulted and raped by a member of staff while she was an inpatient in 2018. Please tell us what you know about that, including as much information as you are able.

Treatment at Oaktree Manor

27. The Safegarding Adults Review report by Essex Safeguarding Adults Board included a review of Edwige's care at Oaktree Manor. I therefore know a little about the treatment Edwige received at Oaktree Manor, but only what is covered in the SAR report. I understand that Oaktree Manor specialised in patients with learning disabilities and that Edwige was sent there after a flawed IQ test was conducted at her previous hospital. My solicitor has reminded me of the following details from the SAR report on this issue:

    a. Towards the end of May 2017, an assessment of Edwige's cognitive functioning was completed by psychologists at Huntercombe Hospital. This appears to have led to a formal diagnosis of Learning Disability being made, and NHS England therefore being advised to provide a bed in a specialist unit for working with people with a Learning Disability.

    b. The report from the cognitive assessment completed on 25 May 2017 which concluded Edwige had a Learning Disability failed to mention several significant factors which may have reasonably contributed towards Edwige's performance in the assessment and may consequently undermine the report's conclusion that he had a Learning Disability.

    c. The consequence of the above report was that Edwige was transferred for a bed in a Specialist Learning Disability Unit (Oaktree Manor), only for her team at Oaktree Manor to have concluded by the time the unit closed that Learning Disability was no longer the main component of her presentation. The report concludes the most likely explanation is that Edwige did not have a learning disability.

28. It just seems wrong to me that Edwige could have been sent to the wrong type of hospital to be treated for something she didn't have and yet remain there for a year. I find this very worrying,

especially as she was being detained for the whole time she was there. I have never known Edwige to have had a learning disability from when she was younger. She was always great at her school work and was getting certificates and awards for her work or for sports. I want to know who was in charge of her health at the time and how this could be allowed to happen.

29. The Safeguarding Adults Review report also included a section relating to allegations of sexual abuse and neglect which Edwige made in September 2018 and concluded these were not properly investigated by Essex Police. I have been reminded of the details from this report by my solicitor, which are as follows:

    a. On 3 September 2018 Oaktree Manor reported a potential sexual assault to Essex Police. It stated that Edwige had reported to a member of agency staff that a male staff member had entered her bedroom on 31 August 2018, had kissed her and expressed feelings for her. A police investigation into the offence of a Care Worker Engaging in Sexual Activity with a Person with a Mental Disorder was opened.

    b. Records from the hospital suggest the staff member was informed of the allegation and went on leave.

    c. On 7 September 2018 Oaktree Manor updated Essex Police that Edwige had reported the same staff member had had unprotected sex with her.

    d. CCTV was reviewed by the Director of clinical services at Oaktree Manor and he reported to the police that it showed the relevant member of staff holding hands with and hugging Edwige. The director informed the police the member of staff would be suspended.

    e. On 3 October 2018 Edwige was interviewed informally by the police. During the interview she stated she was in love with the suspect, they had a consensual relationship, she had had sex with him on six occasions, all in the en-suite area of her room at the hospital. The first three times were consensual but the following three he made threats that he would tell people her secrets. The police concluded there were potential offences to investigate and they would need to conduct a formal interview with Edwige and the suspect.

    f. On 3 November 2018, the hospital completed an internal review into the incident. Their report, which considered CCTV from 15 August to 30 August 2018, includes several observations of the staff member hugging Edwige, then going into rooms alone with her, play punching and walking together with her. It includes that the staff member denied having a sexual or romantic relationship with Edwige but acknowledged he saw himself

as a father figure to Edwige. It also includes that he acknowledged hugging Edwige but claimed this was just for reassurance and was not sexual. The report concluded the staff member had shared personal information with Edwige and that he had breached professional boundaries and relational security by hugging Edwige. It did not uphold the allegation that he had a sexual relationship with Edwige due to lack of evidence.

g. The police requested the CCTV and a copy of the internal investigation report from the hospital on 15 November 2018. They made attempts to arrange an ABE interview over the following weeks but this did not occur due to the unavailability of the social worker.

h. On 15 November 2018 the police spoke with Edwige's social worker who had interviewed her about the allegations. They were informed there was doubt about the allegation of rape, as Edwige had disclosed that she thought voices in her head had told her something had happened rather than something actually happening.

i. The hospital shared their investigation report with the police.

j. On 7 March 2019, the police concluded there was not a reasonable prospect of conviction and decided there would be no further action.

k. The SAR report made the following criticisms of how the police handled Edwige's allegations:

    i. There was a lack of momentum in the police's investigation. That it took one month for an appropriately trained officer to see Edwige was contrary to guidance on conducting ABE interviews that they should be undertaken at the earliest opportunity as delay can lead to memory contamination.

    ii. It was problematic that the police allowed the hospital's own internal investigation to take primacy over their own, given it related to allegations of serious criminal wrongdoing against its own staff. Given there was a known victim and suspect, professional witnesses and CCTV evidence, an effective and proportionate criminal investigation could have taken place over a short period.

    iii. The delays in the police investigation meant there were many opportunities to gather further information that were missed, which might have been more important in reaching a more authoritative view on the allegations given they were,

on face value, credible. The report notes the potential for ongoing risk to others arising from the fact that the relevant staff member is likely still working.

30. I think what was done by both the staff at Oaktree Manor and the police was just wrong. I think they just tried to confuse her. She had said her truth, but she's a mental health patient so they just confused her and suggested to her she was hearing voices. They made her feel bad about speaking her truth. The fact that this person could still be working in a hospital is messed up. My sister was a vulnerable person. The police are supposed to protect her. Instead they just allowed the hospital to take care of the investigation themselves, which they could have twisted it in their own way just to save the person and themselves. There is even CCTV footage showing Edwige and this person going into room, which supported what she was saying. I think there was a lack of responsibility on the police side. And for the hospital to allow a staff member to get close to a patient like that. It makes me very sad. I think Edwige was telling the truth, but the hospital just tried to save their staff member. I am very concerned that this staff member could still be working and this is something I would want the Inquiry to address.

Treatment

Concerning any mental health diagnosis Edwige received:

- *g. What treatment, if any, was offered at the time of diagnosis?*
- *h. By whom was that treatment offered? Where was it to take place?*
- *i. Did she undergo that treatment?*
  - *a. If not, why was that?*
  - *b. If so, over what period did she receive that treatment?*
- *j. Where was that treatment (for example, in the community, or in a particular unit)?*
- *k. Were there any changes to Edwige's diagnosis over the relevant period? If so, please provide details of those changes.*
- *l. Were there any changes to Edwige's treatment, over the relevant period? If so, please provide details of those changes.*

Do you have any observations, comments or concerns relating to Edwige's initial or later diagnosis or treatment, or in relation to any lack of or failure to provide a diagnosis?

Do you think that decisions about Edwige's mental health treatment were made adequately and appropriately? If not, what aspects of decisions about her treatment do you think were not appropriate or adequate and in what way?

What therapeutic care was available for Edwige (either one-to-one or in a group setting)?

Do you think that the mental health treatment actually provided to her was adequate and appropriate? If not, being as specific as you can, in what way (and in relation to what specific aspects of treatment) do you think that her treatment was inappropriate and/or inadequate?

Do you have any concerns about any decisions that were made about any treatment (for example ECT) or medication that was prescribed (or not prescribed) to Edwige? If so, please give details about those, explaining the nature of your concerns and when and how they arose. These could include prescribed, the dosage, the effects on Edwige or any other matters that you wish to tell us about.

Do you have any concerns about how any medication that was prescribed to Edwige was administered and managed? If so, please explain your concerns and how and in what circumstances they arose, giving as much detail as you can.

St Andrews Essex

31. My solicitor has reminded me of the following details of Edwige's treatment at St Andrews, which were summarised in the two reports prepared following investigations into Edwige's death conducted by Psychological Approaches and Essex Safeguarding Adults Board (see paragraphs 96 and 103).

    a. DBT was supposed to be the main psychological treatment at St Andrews which includes individual therapy, 2x weekly skills group and ad-hoc skills coaching.

    b. Other psychology groups were supposed to be available on the ward, including relaxation, a DBT orientation group, incentive /motivation drop in and compassion focused therapy.

    c. Edwige's regime also included Occupational Therapy sessions such as fitness and cooking.

    d. A medication regimen consisting of the following:
        i. Regular use –
            1. Viscotears 0.2% eyedrops - one drop per eye – 4 x daily (for dry eyes)
            2. Fluoxetine 20mg - once x daily (anti-depressant)
            3. Lamotrigine 50mg – twice x daily (mood stabiliser)
            4. Loperamide 2mg - twice x daily (anti - diarrhoea)
            5. Procyclidine 5mg – three x daily (anti-parkinsonian for side effects of depot)
            6. Zuclopenthixol Decanoate injection 400mg weekly
        ii. As needed use –
            1. E45 cream – apply to affected areas as required up to every 8 hours (for dry skin)
            2. Gaviscon advance suspension – 5-10ml when required up to every 6 hours (antacid)
            3. Haloperidol 2.5mg – 5mg – orally or by injection – every six hours as required to a max of 10mg/24hrs (anti-psychotic medication)
            4. Loperamide capsule – 2mg when required up to every 4hours - maximum 8mg in 24hrs (anti – diarrhoea)

5. Lorazepam 1mg – 2mg – orally or by injection when required to maximum of 2mg / 24hrs (anxiolytic)
6. Mefenamic acid – 500mg when required up to every 8 hours, maximum 1500mg in 24hrs (for period pain)
7. Paracetamol tablet – 1000mg when required up to every 4 hours, maximum 4000mg in 24 hours and maximum 4 doses in 24hrs (for aches and pains)
8. Promethazine – 25mg – 50mg - orally or by injection every 8 hours when required to a maximum of 100mg / 24hrs (for agitation)

e. A care plan in which she worked towards the goal of home visits, monitored through weekly 1:1 meetings with her care coordinator.

32. From the evidence I heard at the inquest, I understand that Edwige was initially unsettled when she moved to St Andrews and that there were lots of incidents of self-harm and aggression from her admission until around August 2019. However I am not aware of the details as this period of her time at St Andrews as this period did not feature much at the inquest.

33. I also understand there was a period from August 2019 until December 2019 where Edwige had made good progress with her treatment and that this was mostly down to her being able to have home visits with her family again. My solicitor has reminded me of the following evidence from the inquest of her Care co-ordinator **[I/S]** on this:

a. During a care co-ordination session on 3 August 2019, Edwige reported she was doing well, but feeling low, missed her family and was still struggling with voices. It was noted she displayed no risk behaviours during the previous week;
b. During a care co-ordination session on 8 August 2019, Edwige stated she had started DBT and it had given her techniques to help when she was struggling
c. During a care co-ordination session on 17 August 2019, Edwige said she was still hearing voices but she was managing these with interventions. She said she was utilizing some of the skills she had learnt in the DBT sessions she had been attending. He made a nursing observation afterwards which recorded Edwige's risks as being low as she had not displayed any risk behaviours.
d. By 22 August 2019 Edwige had remained settled and they were beginning to put together a leave plan
e. During a care co-ordination session on 5 September 2019, Edwige reported she was doing OK but she had punched a wall. She reported she had calmed down soon afterwards using positive coping strategies. She was motivated to get back to a low level of risk

f. During a care co-ordination session on 13 September 2019, Edwige really engaged with her treatment, she was utilising the DBT skills she had learnt and was motivated to obtain leave in the grounds and then s17 leave in the community. It was also noted Edwige had started cooking sessions and was showing good insight into managing her mental illness.

g. Edwige had a really settled period for the remainder of September and all of October 2019, with only one blip noted. She was utlising her DBT skills she had learned and there were no ligature incidents.

h. As a result of Edwige's progress, she was able to have four hours of unescorted leave at the family home on 23 November 2019. Afterwards Edwige reflected to him on the progress she had made since arriving at St Andrews. He felt this was a big step and showed she was improving.

i. Edwige said to him she had been in a good mood but that when she goes home sometimes she has a come down after the excitement of leave. She reported her leave went well and she is hoping to have unescorted leave overnight in the future. She was not presenting with risk behaviours. She said her leave visit to her family had gone well and that the relationship wit her family is strong and credits this as a big part of her recovery.

j. On 7 December Edwige reported feeling a bit down over the past week, but also overwhelmed and excited about her progress. She was motivated to have more home leave with her family.

k. Edwige had overnight leave or 2 nights from 24 to 26 December 2019. She reported to him that it had gone very well and she would like more leave in the near future. She had said there were lots of people in the house, reported she had gone to lie down in her room at our mum's suggestion on feeling overwhelmed and that this had made her feel much better.

34. My solicitor has also reminded me that the investigations into Edwige's death made the following findings in respect of Edwige's treatment at St Andrews:

a. The SAR report found:

i. St Andrews did not appear to be suitably resourced to offer consistent psychological support as required for DBT.

ii. There was a period of relatively frequent engagement with a DBP therapist and skills group from August 2019 until January 2020. The report comments this coincided with an improvement in her condition.

iii. However, only one DBT session was offered to Edwige in January 2020, when there should have been six sessions offered. The report comments this was the period when she would have most benefitted from DBT.

b. Psychological Approaches made the following findings in respect of Edwige's treatment at St Andrews before January 2020:

i. They believed Edwige settled after the CPA meeting in 13 August 2019. They say the reason for this was a combination of '*establishing a sense of security with the team on Colne Ward, the therapeutic programme she received which was based around an adapted DBT programme but also included OT sessions which she enjoyed such as fitness and cooking, an effective medication regime and agreed goals to work towards, namely visits home. She had a good relationship with her care co-ordinator which included regular 1:1 sessions whereby progress against agreed goals in her care plans were reviewed. She attended the community meeting and appears to have established a positive role within the ward community. She also established a relationship with a male patient on another ward in the unit which she valued and which was closely monitored by her clinical team.*'

ii. They believed there were complications regarding Edwige's home visits. Edwige had informed staff she did not want her history or details of her mental health condition to be raised with us. Her team judged her to have capacity to make this decision. However, this meant that the leave took place without us being fully aware of her risks and without her past allegations being resolved. They believed the absence of a clinical psychologist dedicated to Colne Ward undermined decision making on this issue.

iii. At the inquest, Consultant Psychiatrist **[I/S]** stated it was important to remember that Edwige also had a diagnosis of complex PTSD, in addition to EUPD. One of the symptoms of this is avoidance. Helping people to be able to look back and use words rather than actions is an important part of the therapy. That step hadn't really happened. Given this, she said the timescale for Edwige improving would have been many, many months, if not years.

iv. Dr **[I/S]** in her evidence, added that people with the diagnoses Edwige had do tend to find transitions extremely difficult. In her view this was what they saw in respect of the four-month period from August to December 2019. The second big transition was reconnecting with the family.

35. It seems as though the DBT therapy was helping Edwige when she was received this. As it was something that was helping her, I want to know why they stopped it in January 2020 when they saw her behaviour was changing. Was it just because they were short-staffed? They surely could have prioritised giving her at least some therapy sessions during this period. It looks like they just did not make any effort to give her the support she needed.

Restrictive practices

Do you have any concerns regarding any restrictive practices used during Edwige's time as an inpatient?

As far as you are aware, was Edwige ever subjected to any form of physical restraint by staff?

If she was,

a. *How and when did you come to learn about that?*
b. *Do you know when, why or in what circumstances Edwige was physically restrained?*
c. *Do you have any concerns regarding:*
    i. *the restraint/level of force used or*
    ii. *the basis for using physical restraint techniques?*

Do you have any other concerns, either generally or in relation to specific examples or events, about how risk was managed on the ward? If so, please provide details.

36. I did not hear any detailed evidence of restrictive practices at Edwige's inquest as that was largely focused on the events leading to her death. However my solicitor has summarised the contents of Edwige's medical records since the inquest. I am aware that Edwige was restrained and placed in seclusion on many occasions at both St Andrews and Oaktree Manor. I understand the records at St Andrews refer to Edwige being restrained by staff on 14 occasions, sometimes by as many as 5 staff members, men and women.

37. I think it's a big concern to learn that Edwige was restrained and secluded as much as she was. It seems to me that being restrained by two people should be enough. Having three or more people restrain you, including men, is a lot for a young woman. There is no need for that. I don't know if this happened so much because she was perceived "an angry black woman" by staff. I am aware the records refer to Edwige as being like a "London Gangster". Edwige was brought up in London, so where she was from she would have no choice but to protect herself. Does that mean there needed to be so many members of staff to restrain her? She probably felt like she was in a prison. She just needed help with what she was going through at the time. I am aware from her inquest that she would put herself in the Extra Care Area to isolate herself sometimes. I feel that for her to have that mentality shows she just wanted to help from staff and did not want to be a risk. She should have been given that help.

Engagement

To what extent was Edwige involved in and/or informed about decisions relating to her care and treatment?

Do you consider that that level of involvement was appropriate? In what way was it appropriate or not? Please explain your views.

Thinking about the same period of time, what can you tell us about how staff, healthcare and other professionals communicated and engaged with you and/or other family members or friends?

For example:

a. *To what extent were you involved in decisions relating to her care and treatment? This can include decisions about Edwige's physical health as well as mental health care and treatment.*
b. *To what extent were you able to input into those decisions, for example by providing information about Edwige's history or character?*
c. *Do you consider that you were listened to?*
d. *To what extent were you informed about decisions relating to Edwige's care and treatment?*
e. *Do you have any concerns regarding the extent to which you and others in her support network were involved?*

When she was an inpatient:

f. *Were you able to contact Edwige when you wanted to?*
g. *Were you able to visit? How frequently?*
h. *Could Edwige contact you?*
i. *Were you able to pass information to or seek information from staff on a regular basis?*
j. *Do you have any concerns about the extent to which you (and/or other family members or friends) were able to*
    a. *Make contact with Edwige and/or*
    b. *Provide or receive information about her?*

38. We were not able to contact Edwige whenever we wanted. She would always be the one to contact us while she was at St Andrews. I remember she did have a mobile phone for a while, I think my mum gave her one or she bought one herself. But she didn't often have it as she would tell us that her phone got taken away, or she was calling us from her friend's phone. There would often be months going by where we had no contact from her. We were not able to contact her when we wanted as we had no number for her.

39. I remember there was one time we visited her. I think my mum had been contacted by the St Andrews social worker [I/S] and he had said that Edwige wanted us to come and visit. I remember being taken to a room where Edwige introduced us to one of her friends. She said they were starting to read the bible together. I remember this as I still have a copy of this bible, which is in French. I remember it as a very short meeting, just to see how she was doing at St Andrews as it was new. No more than 30 or 40 minutes.

40. I recall that we were not generally allowed to come to St Andrews for visits. It was not like some of the other places Edwige had been, where she was able to say come this or that day. My understanding was that the SW was our only point of contact from St Andrews and he always just called my mum. He never said here is my number if you need anything to contact him. He would just call and say Edwige was excited to come home. He was making so many promises to us about this, which were giving us strength and energy. He was saying to my mum, don't worry your daughter will come home. At this point we didn't even know she was in a mental health hospital, and so this was all we knew. He seemed very sure of the plan. He kept saying the plan is for her to come home, and was saying there's a big chance of her doing it as permanent. We were so

excited she as coming home, we just wanted to comply with the process and didn't question it. When we saw her, we thought she was fine. All we knew was that she was taken away years before by social services, so my mum just thought it was still them who were in charge of her. She had no idea they had stopped their involvement with her when Edwige turned 18.

41. There was one time when my dad attended a meeting at St Andrews, but he didn't understand anything as no interpreter was provided for him. My solicitor has informed me from Edwige's medical notes that this was the Care Programme Approach meeting that took place on 18 August 2019. I think my mum was busy so my dad had to attend instead, as someone had to be there to represent her. The SW had also informed us that this meeting would tell us stuff about when Edwige would be coming home. My dad speaks only very basic English. There's no way he would have been able to follow a discussion about Ediwge's care plan. It would have been clear to everyone at the meeting that he didn't speak any English as he probably would have just been smiling and nodding. Edwige told him she would translate for him, but she just told him everything was fine and so that's what he thought. I now understand from my solicitor that the notes of the meeting say the opposite, that they were considering moving Edwige to a more secure unit due to the severity and frequency of her risk incidents. My solicitor has also informed me that the notes even say Edwige asked for a translator for him. If one had been provided that would have made such a difference for our understanding of what was happening with Edwige at St Andrews. That meeting was for us to be involved and understand what was going on with her. We could have really been involved. We could have tried to get a contact number for someone at St Andrews to speak to about her care.

Care Management and Plans

To what extent, as far as you are aware, was Edwige involved in the plans for her care, including the formulation or implementation of a care plan?

Do you consider that the level of engagement with Edwige about decisions and plans in relation to her care and treatment was appropriate? If not:

a. *Why not?*
b. *What do you think should have been done differently?*

To what extent were you, or other family members or friends, involved in or informed about the plans for Edwige's care, including the formulation or implementation of a care plan?

Do you consider that the level of your (or other family members or friends) involvement with those plans or the level of information provided to you about the decisions and plans in relation to Edwige's care and treatment was adequate and appropriate? If not:

a. *Why not?*
b. *What do you think should have been done differently?*

Do you have any concerns about any aspect of the formulation or implementation of the care plan? If so, please describe those concerns.

42. We did not know anything about Edwiges care plan while she was at St Andrews. My only knowledge about Edwige's care plans comes from what I heard at her inquest.

43. My solicitor has reminded me that Edwige's care co-ordinator [I/S] said the following about Edwige's care plans at her inquest:
    a. He would design her care plans once every two weeks.
    b. He would meet with her for around an hour every two weeks for this, but would also see her several times between on an ad hoc basis.
    c. For a care-coordinator session, they would usually go to a quiet room. These were normally more structured sessions.
    d. He would design her care plan according to what she wanted.
    e. Edwige's main goal was to get home to her family. She really loved her family and was very specific that she wanted to get out to be with them.

44. Our family had no involvement in formulating any of Edwige's care plans. This kind of information was not shared with us at the time. No one from St Andrews ever even contacted us to inform us what mental health conditions Edwige had.

45. My mum was contacted by someone called [I/S] from St Andrews who informed her about arranging home visits for Edwige. My mum gave the following evidence about this in her inquest witness statement:

    a. One day a man from St Andrews called and introduced himself as [I/S] He said he was a social worker.
    b. He told her that Edwige was asking to come back home.
    c. He visited our home around April or May 2019 for an inspection, following which he told us Edwige would be allowed to come and visit us.
    d. Subsequently, Edwige came to visit us. She was accompanied by two workers from St Andrews.
    e. After this, she had a call from St Andrews who said they wanted Edwige to come home more often. At the same time Edwige was saying that she wanted to come back home.
    f. In December 2019 the SW called her and told her Edwige could spent Christmas and New Year at home with the family.
    g. Edwige was dropped off home for Christmas on 23 December 2019 and she stayed until 26 December 2019. The visit went extremely well. Edwige appeared very happy.

h. I was in hospital at the time but was able to return home for 2 hours to see Edwige. She was very emotional when she saw me and told my mum not to worry and that better days would come.
i. After Christmas, mum was told by the SW that Edwige would come home again on 31 December, and we would have to return her on 1 January 2020.
j. My condition deteriorated while I was in hospital, and Edwige was aware that I was sick and was very supportive.
k. My dad dropped Edwige back at St Andrews at 3pm on 1 January 2020.

46. I remember Edwige coming home that Christmas. I was in hospital at the time when my mum told me Edwige might be coming home for Christmas. I was so happy to hear it I just wanted to get out. I thought this is it, the biggest change in all of our lives to have Edwige back home where she belongs. I was telling my nurse I was fine, I just wanted to get home and I was really happy and excited. I was allowed to leave hospital for Christmas. Edwige was there when I got home from the hospital and was happy to see me. I remember getting dressed up, dancing and singing all together with her. I have so many videos I was posting from that visit. It was just our whole family together, like how it was in the beginning before Edwige was taken away by social services. Sitting at the table with her was such a big thing. We were all having dinner and laughing. I was very happy and did not want to go back to the hospital.

47. We were very happy to see Edwige and so I am sure we would have been supportive of the main goal of the care plan if we had been informed about it at the time. We were very happy to hear that after all these years she was finally coming home. We all wanted this to happen. However, looking back we do not support the way St Andrews went about arranging home visits for Edwige. We feel that St Andrews should also have given us some information about Edwige's mental health condition, as none of us realised how vulnerable she was.

48. For us it all just seemed like things were back to normal with Edwige. She seemed fine and healthy. We saw she was a bit overweight, as she used to be thin, but we didn't think this was anything unusual. We had no idea what she was going Edwige before the visits, or told them there was anything they needed to be aware of with Edwige, or that there were things that could trigger her. They just dropped her off by at my parent's house, and that was it. They didn't even get out of the car with her on the occasions I remember. We had young kids in the house, as my three younger siblings were between the ages of 6 and 9 at the time. We also have a lot of objects in the house which Edwige could have used for self-harming. I have a lot of stuff in my room, like sewing and arts and crafts stuff. As St Andrews didn't give us a plan, we all just assumed she was fine. She was acting fine and we were not told any different.

49. Edwige herself said she was fine. She just said she was fine and happy to be home for Christmas. She was asking how stuff was going for everyone else. Whenever we asked about her, she just said she was fine and was ready to come back home. That was it. It makes me feel very sad and shocked to think back to that time and realise that this was someone who was going through a mental health crisis. She was supporting everyone else, she was supporting me, but she might not have been looking after herself.

50. I am shocked that no one sat us down and told us this was what she was going through or discussed anything could have triggered her. Looking back, anything could have happened while she was with us and it would have been on our hands. Anything could have triggered her. We just had no clue at the time.

51. I am aware that the reason given for not telling us was that Edwige didn't want to tell us about her mental health problems. But I feel that the staff at St Andrews could at least have had a conversation with Edwige that she had to let her family in a little bit to her problems if she was going to return home. They could have eased her into this and given her more support to enable her to have the strength to tell us some of the things that were going on with her. As it was, they just dropped her off with us, with us having no idea about any of her risks. If she were to have had a breakdown with us, she would have had no protection.

52. We were supportive of her coming home but not the way it was done, which excluded us from having any responsibility for ensuring she was safe. We were just happy to have her home and excited to see her. We would have done anything to have her home. Now looking back, there was all this history which we had no idea about. It is upsetting for us to think that we had no clue of what she was going through at that time.

Individual circumstances

Did Edwige have any individual conditions or circumstances that should have been taken into account while she was being treated as an inpatient (for example neurodiversity, learning difficulties or disabilities, physical health issues or addiction concerns)? If so:

k. Please tell us about those individual circumstances.
l. Were the staff who were assessing, treating and/or making decisions about Edwige's treatment or involved in her care aware of those circumstances or conditions?
m. Do you think those individual circumstances were appropriately considered and taken into account to a sufficient degree?
n. If not, please explain your answer. For example:
    a. What leads you to think that no proper account was taken of Edwige's particular circumstances? Are there any examples you can provide of a failure to do so?
    b. What do you think could and should have been done to ensure that those circumstances were recognised, considered and used to ensure appropriate care and treatment?
    c. If those circumstances had been properly taken into account, in what way do you think the care and treatment of Edwige would (or should) have been different?

53. One thing we noticed when Edwige came home in 2019 was that she did not know any of the foods that we used to eat when we were younger, and she had lost the ability to speak Lingala which she used to speak with my parents. It seems that it wasn't really part of the plan for her to support her cultural heritage while she was at St Andrews and other hospitals.

Staffing Arrangements and Support

Did you have any concerns regarding the number of staff on the ward at any time? If so, please provide details, for example:

a. What were those concerns?
b. How did the matters you were concerned about come to your attention?
c. When was that?
Over what period?

In your application for core participant status, you explained that at the Inquest into Edwige's death, evidence was heard that the unit had an acute staff shortage at the time of her death. You also told us that one nurse gave evidence that he believed that shortage would have impacted decision making around risk management. Is there anything further that you would like to tell us about that evidence or about your views on it?

54. My solicitor has reminded me of the following evidence from the inquest in respect of staffing levels on Colne Ward:

a. Edwige's care coordinator at St Andrews, **[I/S]** gave evidence that there were challenges with staffing both at ward level, as there was a national shortage of nurses and healthcare assistants, but additionally the ward manager and the responsible clinician both went on leave unexpectedly shortly before Edwige died. He stated the ward manager was off sick at the time and other nurses were having to deputise. He described staffing at the ward as "horrendous" in the leadup to Christmas 2019, stating they did not have enough nurses and often not enough support workers. He stated that if there was an incident staff would have to respond leaving them with less capacity for other things. He stated that the ward at the time of Edwige's death was extremely unsettled to the point of being unmanageable, and that staff did the best they could in extreme conditions. He stated they had a very challenging patient group in Colne Ward at the time, describing them as 16 very unwell patients. Most patients had EUPD which was characterized by impulsive behaviour, and so when one patient ligatured it would often lead to other patients ligaturing. He stated there were multiple incidents on a every day, and as many as 6 or 7 ligature incidents a day at its height.

b. Senior Nurse **[I/S]** said Colne Ward gave similar evidence, saying the ward could be a challenging place to work given its service group tended to be women with personality

disorders who had a high level of acuity. The ward was under even more pressure at the time of Edwige's death as the acuity of the patients on the ward was high and the ward manager and responsible clinician went on unplanned leave shortly before Edwige died. She stated that everyone did their best to care for the patients in challenging circumstances. When asked if she had any concerns about staffing levels and the ward's ability to meet patients who might need more intensive observations, she stated yes she worried they didn't have this, as their management and Responsible Clinician were not available. She had concerns and she raised them with the MDT. She said that sometimes you just have to pull together and do the best you could do. She also pointed to there being a national problem with recruitment in this area at the time, saying there was a shortage of psychologists and also that it was a challenge to recruit HCAs in January 2020. In her statement she said Colne Ward could be a challenging place to work given its service group tended to be women with personality disorders who had a high level of acuity. The ward was under even more pressure at the time of Edwige's death as the acuity of the patients on the ward was high and the ward manager and responsible clinician went on unplanned leave shortly before she died. Everyone did their best to care for the patients in challenging circumstances.

c. Giving evidence on staffing levels 3 February 2020, senior nurse **[I/S]** stated they had six staff members on the ward that day which was not adequate. He stated that on a ward with 16 patients, safe staffing would be determined by the number of patients on enhanced observations. This would be around 7 – 8 staff members. He also stated that he was away from the ward for most of the morning on 3 February 2020. The Coroner pointed out that while he was off the ward this would have left two qualified nurses and three HCAs and asked if this would be sufficient, to which he replied it was not sufficient but it was safe.

d. When senior nurse **[I/S]** was asked if they were short staffed at the time during the inquest, he responded by saying from a technical perspective standpoint no but that this does not mean it was not difficult to juggle the resources they had. He accepted that putting a patient on 1:1 observations was intensive in terms of staffing. He stated he didn't know if it was a factor in the decision to not put Edwige on 1:1 observations and that he didn't recall it being discussed. He stated that in an ideal world staff shortages would not be a factor in these decisions but in the real world it often was. It is this part of his evidence that our solicitor referenced in our CP application. It seems clear to us from the evidence we have heard that the decision making about Edwige's observation levels must have been impacted by the staff shortages in Colne Ward at the time.

e. [I/S] was only doctor working on Colne Ward when Edwige died. When he was asked at the inquest if they had enough staff to carry out 1:1 observations if they had assessed the need for this on 3 February 2020, he answered that it was difficult at the time but they could have escalated or organized things if they felt that Edwige needed 1:1 observations. He accepted that staff shortages would not be a good reason to keep a patient on the same level of observations if they felt they needed them to be increased.

f. Several staff members reported in their witness statements that there was a meeting to discuss the staffing levels at around 14.00 on 3 February 2020.

g. During the inquest, the following extract was read out during the evidence from the Minutes from a Ward Management Team Meeting on 16 January 2020:

> *The staffing levels on the ward has been challenging over the Christmas/New Year period – with staff leave, sickness and relocations. This continues to be an issue.*
> *- Reflective practice has seen a number of staff tearful due to feeling unsafe and overwhelmed on the ward. This was due to the problems regarding staffing and poor communication.*
> *...*
> *'Staff in MDT described being deflated and at times overwhelmed by the ward.'*

h. The report by Psychological Approaches gave the following summary of the staffing issues at Colne Ward in early 2020: '*Unfortunately [Edwige's deterioration] happened against a backdrop of the ward struggling. The nurse manager had been on sick leave since 1st January and the ward consultant, Miss BP's responsible clinician was on annual leave from 20th January. The principal psychologist for the ward had left in May 2019 and the post remained vacant. Two qualified psychologists from other wards at SAH Essex were covering Colne Ward between them but had limited capacity given their other responsibilities. They were able to provide minimal psychological input for Colne Ward, and operated in remote roles, focusing on supervision, community meetings, CPA reports, HCR-20s and reflective practice for staff but were not able to function as full clinical team members, offering consistent psychological leadership and advice. Taken together, the responsible clinician's leave, the nurse manager's sickness and the absence of a dedicated qualified psychologist had a considerable impact on the ward in terms of its capacity to contain complex patients' distress and disturbance. Consequently, despite a clinical nurse leader acting up, the remaining front line staff were considerably impacted. We heard this in our meetings with professionals whereby it was frequently stated that the*

team were completely overwhelmed, with high levels of violence and self-harm by patients and some staffing problems as well.'

i. A CQC inspection of St Andrews Essex took place immediately after Edwige died and it found that there were not enough registered nurses and support staff at the hospital to keep patients safe.

55. From the evidence I have heard, I have serious concerns about why St Andrews did not have enough staff on the ward to keep patients safe. It seems there was a shortage of staff at every level of seniority. I think this was one of the main reasons why Edwige died.

56. I just don't get why no one at St Andrews ever sorted this out. In my own personal experience working as a nurse in a hospital, when I go into a ward they always know how many staff there will be. When we get in, we talk about the staffing levels to ensure we have enough, before we even talk about the patients. It is the main priority. If one nurse or staff member is missing, there is a system in place which will mean we will always find someone to replace them, maybe from another ward or they would bring someone in on a rotation. I just don't understand how on Edwige's ward they could have staff missing at every level for that long. I would expect there to have been some sort of plan B for when normal staff members were absent, but it doesn't look as though there was. It doesn't look as though St Andrews was capable of providing substitute staff members from within the organisation.

57. I would have thought this was particularly important, given what staff members say about Colne Ward being a particularly heavy ward, with patients triggering other patients to self-harm. If you know you have these types of patients on your ward, it seems particularly important that you would not allow it to be run in a way that allowed the possibility of significant staff shortages for an extended period. I am worried this will happen again at wards run by St Andrews. I do not know if it is because they are a privately run hospital that they did not have a big enough organisation or systems in place to ensure they had enough staffing at all times. It seems they were just too slow at filling vacancies, and had no answer for situations when staff members were absent. I would like to know why St Andrews were so slow in finding replacements for absent staff in 2020, even though it was a safety issue.

Safety at St Andrews Essex

In your application for core participant status, you have explained that Edwige was able to seriously harm herself on numerous occasions while on the ward before her death. Please tell us what you know about each such incident, again including as much information as you are able.

Do you have any concerns regarding the observations that were in place for Edwige and/or about the way in which those were carried out? Please could you provide details. In particular, the Inquiry notes that in your application for core participant status you explained that:

a. *Following her return from leave over Christmas 2019, Edwige's condition rapidly deteriorated and there were regular incidents of self-harm such that staff increased her level of observations to intermittent 15 minutes and placed her in a sterile room with rip proof clothing on 13 January 2020;*
b. *Despite this, she continued to seriously harm herself, and yet further measures were not taken to manage her increased risk, such as place her on more frequent or constant observations;*
c. *On 3 February 2020, Edwige's risk was being managed on the same regime that had been set on 13 January 2020. She was observed by a Health Care Assistant at 15.30, but that HCA then had to leave the ward. No staff member left on the ward recalled her handing over responsibility for observations;*
d. *Edwige was found by a senior nurse at 15.55 with three ligatures around her neck;*
e. *The senior nurse initially believed that Edwige was 'feigning unconsciousness' and so did not immediately commence CPR upon removing the ligatures;*
f. *The senior nurse left Edwige with a second nurse while he went to get an oximeter and then the second nurse left Edwige on the floor while she dealt with another incident;*
g. *All of this resulted in a delay of 8 minutes in staff calling a medical emergency, leading to staff beginning CPR 2 minutes later at 16.05.*

You also told us in your application for core participant status that there were occasions when measures to manage increased risk (such as more frequent observations) were not taken, for example following serious incidents of self-harm. In relation to each such occasion:

h. *Do you know why a decision was taken that formal observation at particular short intervals was not needed? What were you (or other family members or friends) told about that, if anything?*
i. *Do you have any concerns regarding that decision? If so, please explain your concerns.*
j. *Would you like to tell us anything further about the failure to place Edwige under adequate observation, or the failure to act promptly upon finding Edwige unconscious?*

Did Edwige ever raise fears or concerns with you or with anyone else regarding her safety or that of another inpatient? If so:

a. *Please describe the incident(s) or event(s) that you know about, including all individuals involved.*
b. *When did those take place?*
c. *When did you come to learn about those incidents or concerns?*
d. *From whom?*
e. *Were any matters affecting the safety of Edwige or any other inpatient reported, as far as you were aware? If so:*
    a. *By whom?*
    b. *To whom?*
    c. *What action (if any) was taken as a result?*

In your application for core participant status, you explained that on 13 January 2020 Edwige was placed on intermittent 15-minute observations and moved into a sterile room with rip proof clothing. Were there other occasions on which Edwige was placed under any particular type of formal observation (for example, with checks to be carried out every 15 minutes)? If so, please tell us what you know about those

In your commemorative account about Edwige, you explained to us that you believe that she experienced mistreatment because of racism. Is there more that you are able to share with us about your views on that and about the basis for your belief?

58. I did not have any concerns about Edwige's safety at St Andrews at the time as I did not know what was going on. It is only after I have learned what happened to her that I have realized how unsafe she was at St Andrews.

59. At the inquest into Edwige's death, the jury concluded that Edwige died by misadventure contributed to by neglect, with the following failures identified:

    a. Inadequate design and completion of observation forms;
    b. Insufficient interaction with patients when carrying out observations;
    c. Inadequate updates of Edwige's care plan after 8 January 2020;
    d. Failure to increase Edwige's observation intervals despite recent escalation of serious incidents relating to Edwige's behaviour and deterioration of Edwige's mental health;
    e. Inadequate record keeping;
    f. Serious delay in declaring a medical emergency for Edwige;
    g. Unacceptable delay in delivering Basic and Immediate Life Support for Edwige; and
    h. Unacceptable delay in notifying emergency services.

60. In addressing the Inquiry's questions on safety at St Andrews I will also outline the evidence I heard which was relevant to the jury's conclusions.

<u>Observations and risk management</u>

61. I understand from the evidence at the inquest that Edwige started to deteriorate when she returned to St Andrews after visiting us for Christmas and New Year and she was placed on intermittent 15 minute observations on 13 January 2020. My solicitor has reminded me of the following details from her medical records on this:

    a. Edwige's patient notes refer to her as being threatening and hostile on 2 January 2020, the day after her return from home leave.

    b. During a meeting with her care co-ordinator she said she had been having thoughts and flashbacks since her leave. She said she had received a call while she was at home from an anonymous number where a male voice had said he was the person who had

previously sexually assaulted her. She said her family were unaware of this and she did not want us to know. She did not want to report it to the police.

c. During a care plan update meeting on 8 January, she reported to her care coordinator she had low mood and an increase in her experiences of hearing voices since returning to the ward after Christmas. She wondered if things had moved too fast and thought it might be sensible to stop her leaves for about a month until I was more stable '*so there would be less stress of overwhelming emotions*.' Her unescorted leave was suspended.

d. On 8 January 2020 she rushed to the toilet and induced vomit after a call with our mum. She then kicked a window and jumped on a chair. She then [I/S] was threatening to tie a ligature.

e. Edwige told staff she was struggling and asked for PRN medication. She later told staff she intended to ligature.

f. She had altercations with two other patients. Following this her observations were increased from general hourly observations to 15 minutes intermittent observations.

62. We also heard evidence that Edwige's condition dramatically deteriorated even after she was placed in intermitted observations and how she was able to seriously harm herself on numerous occasions before 3 February. My solicitor has reminded me of the following incidents from her patient notes:

a. On 18 January 2020 Edwige was recorded as crying loudly due to hearing voices. She was saying she 'wants to die'. She was refusing her medication and said she had not been taking her medication since 1 January. Dr [I/S] give evidence at the inquest that Edwige was not complying with her medication and declined it most days from 28 January until 3 February.

b. On 21 January 2020 Edwige was placed into seclusion after an incident where she was repeatedly punching herself in the face and trying to ligature. The notes say she tried to assault staff when they intervened and she was restrained by five staff members.

c. On 22 January 2020 after her seclusion had ended, she informed staff she had inserted **items into herself to cause infection** [I/S] She later attended Basildon Univesrsity Hospital on 24 January for the

removal of these items. The notes also say staff observed she had a carpet burn where the skin had broken on her left arm on her return from seclusion.

d. On 23 January 2020 a medical emergency was called after she was found having tied two ligatures tightly around her neck and was limp and unresponsive for a period. She then started making laboured noises before having what appeared to be a non-epileptic fit.

e. On 26 January 2020 Edwige came out of her bathroom with a ligature tied round her neck [I/S] which staff managed to untie manually before ligature cutters were obtained.

f. On 27 January 2020 Edwige was observed by nurse [I/S] in the corridor with an item around her neck and threw herself to the floor. Staff went to assist and Edwige had a ligature tied tightly around her neck. Staff had to use the ligature cutters in order to remove the ligature. Edwige was observed to be breathing.

g. On 29 January 2020, Edwige started pacing round the ward and shouted at staff to be taken to seclusion. The notes say she became aggressive when staff refused. She went to her bedroom and pulled the dressing off her hand and was walking round with bleeding hands, refusing to let staff dress her hands.

h. On 2 February 2020 Edwige gave another patient items to self-harm with, which that patient used. Edwige later expressed remorse for this. She was later found to have tied a ligature [I/S]. The notes state that low level MAPA holds were used to restrain her and a ligature cutter was sued to remove the ligature. She was then moved to the extra care suite where she remained for 13 hours.

63. I am aware that Edwige tried to tell staff that she was feeling suicidal and unsafe. Her records include a conversation between Edwige and the psychologist [I/S] on 28 January 2020, during which Edwige shared that she was struggling with lots of things, including the breakdown of her relationship with her peer. She said that she had lost all hope, she wanted the pain to go away and that she had been tying ligatures in hope of killing herself to end her suffering. She said that she was being overwhelmed by her voices which were instructing her not to comply with her medication.

64. I am aware of an entry in the medical notes on 30 January 2020 where Edwige reported to Dr [I/S] that she felt unsafe, which says as follows:

a. Edwige was emotional and upset after a community meeting which had recently taken place. Edwige reported that other girls on the ward had raised complaints about her self-harming behaviours in the presence of other patients, at the meeting.

b. Dr [I/S] advised her to be mindful and not involve others in her risk behaviours. Edwige then stated she did not think the ward was helpful to her.

c. She said she wants to be moved to Medium Secure Unit as she did not feel safe on the ward, and that she needed to be on 2:1 ECA.

d. Dr [I/S] explained that this was not necessary at this stage as there was no immediate risk of Edwige's safety from other patients and there had been no incidents of her being assaulted. There were safeguarding policies and protocols are in place and her safety from another patient could be managed within the ward with staff support.

65. I am very concerned that Edwige was clearly in significant distress and was telling staff about this, but they were not listening to her or taking her seriously. There was just no action at all. They were aware of her struggling, as she was asking for support, but they could not even meet her expectations of support. I can see from the notes she was aware of her risk and she was informing them about them, but they weren't listening. They weren't taking any actions to take her safe. They did not take her seriously at all. I don't know why. I find it shocking as these are supposed to be professionals. You expect them to help. She was just expressing her struggles, but they were not taking any action. It seems like they just didn't care at this point. For them, 15 minutes observations was just enough.

66. There was a time where Edwige called me in January 2020, which must have been during this period. I answered her call when I was out. I remember called at around 4-5pm as I think I was coming back from college. She told me she was being bullied by other girls and that no one listened to her. That's all she told me. She said she didn't want to tell much, as she would have her phone taken away. She said someone was listening in. I remember telling her don't let these girls get to you. We just laughed it off. I said something and she laughed. She said she had to go, as she didn't want to get in trouble. Then she ended the call. When I did speak to my mum or dad, I asked if she said anything regarding her safety they didn't know anything. I think she just said this to me. I didn't understand at the time that she was in danger. Now I know what was going on for her at that moment; I realise she was in trouble and was reaching out for help. All she wanted to do was be safe. She was just trying to get herself out of a scenario. She was looking for support but she wasn't getting it when she asked for it. I don't understand why she wasn't supported, as the patient's wants and needs should come first.

67. I understand that Edwige was placed on constant observations on two occasions, earlier during her admission to St Andrews:

    a. On 10 to 15 May 2019 when she was put on 1:1 constant observations due to the risks of self-harm and the risk of assaulting others. This was after an incident where she had tied a ligature, punched herself in the face, and threatened to harm other patients. She was placed on constant observations until her mental state improved.

    b. On 19 to 22 July she was put on 2:1 constant observations due to the risk of self-harm and assaulting others.

68. I am aware that the events which led to these were similar in nature to the events which occurred in January 2020. I am very concerned that St Andrews did not increase Edwige's observations beyond intermittent 15 minutes observations after 13 January. I think they should have increased her observations to constant observations and that this would have saved her life. I don't understand why the team looking after her in January could not just look back at how they managed her in May and July 2019.

69. My solicitor has reminded me of the following details from the evidence of staff members in relation to the observation levels Edwige should have been on:

    a. Dr **[I/S]**, as the only psychiatrist working on Colne Ward in the weeks before 3 February 2020, was questioned on why Edwige's risk management plan was not changed and observation levels were not raised in January 2020. He agreed that the behavior which led to Edwige being placed on constant observations on 10 May 2019 (frequent attempts of self-harm, punching herself, tying ligatures, precipitated by deterioration, aggression and assaulting staff) looked very similar to her behaviour in January 2020. When asked why Edwige's escalation of risk incidents and seclusion had not prompted the MTD to review Edwige's care plan and consider putting her on 1:1 constant observations, he stated they thought Edwige could manage the crisis she was going through with their current plan of keeping her 15 minute intermittent observations, in strong clothing and a sterile room, and that they did not think putting her on 1:1 observations would help her progress. He stated they felt they were managing Edwige well on 15 minute observations and could help her get over the crisis she was going through. When asked to comment on the fact that there were almost daily ligature attempts at that time, he agreed they could have done better at that moment. He agreed they also had the option of increasing Edwige's observations to 5 or 10 minute intermittent observations, but stated that at the

time their focus was on 15 minute observations and that most of their patients were on 15 minute observations at that time. When asked why the notes contained no reference any recorded consideration of increasing Edwige's observation levels, he stated he remembered this was discussed as something they needed to agree on, which was why it was not documented, only to later say that they did not discuss it. When asked if they had enough staff to carry out 1:1 observations if they had assessed the need for this on 3 February 2020, he answered that it was difficult at the time, but they could have escalated or organised things if they felt that Edwige needed them. He accepted that staff shortage would not be a good reason to keep a patient on the same level of observations if they felt they needed them to be increased.

b. Senior nurse **[I/S]** stated that during a handover on the morning of 3 February, he would have been given information about Edwige having shared risk items with another patient and then ligatured the night before. He did not specifically recall this. He was aware she was on 15 minute observations and was supposed to be in a sterile room in strong clothing. When asked if there was any discussion about reviewing her level of observations, he said they had discussed whether to put her on 1:1 observations. He said **the senior nurse** and himself thought she should be put on 1:1 observations but other members of the MDT didn't agree. When asked why, he said because he was unwell and could be quite unpredictable and it was a short period of time since the last ligature. When asked if he would expect this conversation to have been written down he answered, "perhaps, perhaps not". He accepted this conversation should have been written down.

c. Senior nurse **[I/S]** provided a different account of this handover meeting. He just said they decided to continue with the plan that was already in place for managing Edwige's risk. When asked how they were going to understand how she had still been able ligature on the plan and how to mitigate the risk of this happening again, he just said he would have loved to speak with Edwige to get insight into how she had been able to ligature but she was asleep in the Extra Care Suite. When asked about **another nurse's** evidence that they had discussed putting Edwige on constant observations, he stated he could not remember having that discussion. When asked if it is likely he would have thought Edwige should have been placed on constant observations, he said he was unable to say. He said if there were any risk incidents these would be discussed at the MDT, who would have the capacity to review observations based on risk. When asked, he accepted he was part of the MDT that morning and stated their decision was to keep observations the same. When asked why there was no record of that decision, he accepted there should have been a record and he could not explain why there was not.

70. It seems to me as though Edwige came to staff with concerns, but they weren't being taken seriously. Dr [I/S] response appeared to be, it's OK, you can manage as you are on 15 minute observations. That's not how you manage a person. A lot can happen in 15 minutes. Especially if Edwige was struggling and had no help from them, 15 minutes is a long time for her to get through. For her it must have felt like hours.

71. The Psychological Approaches report reached the following conclusions in respect of Edwige's care during January and February 2020:

    a. Although her observations were increased to intermittent 15 minute observations on 13 January, these were carried out at fixed 15 minute intervals rather than randomly within 15 minute intervals to mitigate her being able to time how long she had to plan to self-harm between observations. The observation sheet included times at every hour, and 15, 30, and 45 minutes past the hour, alongside a column for staff to sign next to each time to indicate an observation had been completed. This was contrary to St Andrews' own policy on intermittent observations.

    b. In respect of staffing, the report found that the absence of senior leadership on the ward during this period significantly impacted the care Edwige received. They found some evidence that in the absence of clinical leadership staff were failing to recognise Edwige's severe mental health symptoms and inner distress, instead regarding her actions as attention seeking and indulgent. This included in respect of the fatal incident on 3 February.

    c. There was sufficient escalation in Edwige's risk behaviours from 21 January to have indicated a review of her observations at any point after that date with a view to upgrading them to continuous observations. The strategies in place from 13 January (15 minute intermittent observations, strong clothing and a sterile room) had not contained the risks, in particular of her accessing material for ligatures. They considered her risk to herself justified a period of continuous supportive observations with the aim of supporting her thorough her mental health crisis which would include stabilising her mental health condition, supporting her with medication concordance and helping her to manage her emotional distress and sense of hopelessness.

72. I am aware the report also gives reasons offered by staff for not putting Edwige on constant observations, including it was felt to be problematic due to the staffing implications at a time when the ward felt stretched with regard to staffing levels. This was not something I saw any staff

member admit at Edwige's inquest. The report authors say they believe the absence of senior clinical leadership on the ward was the main factor leading to a reduction in the quality of care Edwige received at that time. At the inquest the report's author Dr [I/S] stood by her conclusion it was justified to put Edwige on continuous observations. She further stated that if there had been any discussion of constant observations where they were not implemented she would have expected this to have appeared in the records. They confirmed it was important for clinicians to record discussions like this so that the next clinician working knows what processes and practices have gone before. I am also aware that St Andrews had previously put Edwige on 1:1 constant observations from 10 to 15 May 2019. This was at a time where her responsible clinician was still on the ward.

73. I am very concerned that the staff at St Andrews did not place Edwige on continuous observations in late January 2021. I feel like Edwige was aware of what was going on with her diagnosis. She was aware she was struggling and was trying to get the support she needed to keep her safe, but she wasn't being listened to. It looks to me as though staff shortages on Colne Ward did play a role the failure to place Edwige on continuous observations. I think staff members did not want to admit this at the inquest because they knew it would not be a good reason not to increase her observations.

Failures to check on Edwige

74. During the inquest several staff members were asked about whether they had properly engaged with Edwige to check how she was doing on 3 February 2020, after she had ligatured the night before and then spent around 13 hours sleeping on the floor of the Enhanced Care Suite until after midday. No one was able to say that they had checked on her welfare or assessed her mental health after Edwige left the extra care suite on 3 February.

    a. HCA [I/S], who was conducting observations for Edwige, was asked if she should have had a conversation with Edwige to see how she was doing after ligaturing the night before in order to understand her risk level. She didn't accept this was a conversation she should have had as she wanted her engagements with patients on the ward to be mood lifting and she did not want to touch on a topic which would bring down her mood.

    b. Senior nurse [I/S] was asked if anyone assessed Edwige's mental state when she came out of the extra care suite. He answered that Edwige was flat so you could not really tell what was on her mind.

c. Dr [I/S] confirmed he did not have any conversation with Edwige about her ligature attempt the night before when he saw her at 1.30pm on 3 February. When asked if he should have, he confirmed he could have done better. He stated he believed the nursing staff would have definitely have spoken to her about the incident the night before. When asked if he would expect such a meaningful interaction to have appeared in the patient notes, he said yes. However there was no record in her notes of any staff member checking Edwige's welfare after the ligature incident the night before.

75. HCA [I/S] was also asked questions about how she carried out her observations. She confirmed that the expectation when she recorded an observation was that she had engaged with the patient. However she completed recorded several observations at 16.00 and 16.15 on 3 February 2020, which would have been after Edwige had been found by a nurse with the fatal ligature around her neck (his evidence was that he found her at t15.55, as summarised below at paragraph 79.a.xiv.). When asked why she had filled in these observations, she said she had no answer. She said she was just confirming she knew where the patient was and there were people with her.

76. From what I saw of the staff giving evidence at the inquest, I feel like the staff just didn't care about Edwige at all. I feel like this is reflected in the fact that they just put Edwige in a room for 13 hours after she ligatured, and then didn't even check in to have a 1:1 conversation with her to check how she was doing when she got out.

77. I am also very concerned that the staff at St Andrews missed the observation of Edwige immediately before she ligatured on 3 February 2020. My solicitor has reminded me of the following evidence on this from the inquest:

a. Edwige's last recorded observation was at 15.30 by HCA [I/S] confirmed Edwige was in rip proof clothing when she saw her, but she did not ask her to lift up her blanket to find out what was underneath. Her evidence was that immediately after this observation, but she was asked by nurse [I/S] to leave the ward to search a patient in reception. She said in her evidence at the inquest she would have handed it over responsibility for Edwige's observations to whoever had asked her to leave the ward but could not remember who, and it was pointed out to her she had said this person was that nurse in her statement.

b. In his evidence at the inquest, the nurse stated that the HCA did not hand over responsibility for Edwige's observations to him when she left the ward. Although he did not mention this in his first account, he admitted in his witness statement taken by the

police that he filled in the 15.45 entry retrospectively sometime later after the incident. He confirmed at the inquest that the police had asked him about this when taking his statement. He said that this was the time when he had found Edwige on the floor with **another nurse, who** was trying to get an oximeter reading from Edwige. It was put to him at the inquest that this was a long time before 16.03, which was **another staff member's** evidence of the time her pager went off calling for a medical emergency. He accepted this and stated he was not 100 percent if it was 15.45 when he saw Edwige. He confirmed that his purpose in filling in the observation on the form at this time was just to record Edwige's location, rather than to say she was alive and well.

78. This evidence doesn't add up for me. I don't understand why the staff members couldn't just tell the truth. It looks obvious to me as though they just missed the observation at 15.45 and then tried to cover it up by filling in the observation form later.

Emergency response failures

79. I am particularly upset by the actions of the staff who first found Edwige during the fatal incident on 3 February 2020 and am not surprised the jury found their actions to be unacceptable. My solicitor has reminded me of the following details from their evidence at the inquest:

    a. **A senior nurse** said:

        i. He followed another patient down the corridor as they weren't allowed to be there unsupervised. As he entered the corridor he saw Edwige lying with her feet out of the door of her bedroom at the far end. When he approached he could see some ligatures tied round her neck.

        ii. He removed the first two ligatures by hand. The last one he cut off by ligature cutters. The ligature appeared to be some kind of cloth. There was a slight release of pressure after the inner ligature was removed, at which point she coughed. She did not open her eyes or respond.

        iii. He discussed the situation with **another nurse** and he decided to get the oxygen saturation machine just to check she was unconscious. He was concerned as he know in the past she had pretended to be unconscious to attack people. When asked how he knew this, he said she told him this herself. He said he recalled one occasion where she had done this since she had been on the ward, although he could not say precisely when this was.

iv. He recalls the other nurse said to him '*she's playing'*. He took him to mean she was conscious and potentially attempting to lure them.

v. He went to get an oximeter, leaving [I/S] on his own with Edwige. When asked why he didn't call the pit alarm for a medical emergency at this point, he stated this was bad clinical judgement on his part. When asked why he felt comfortable leaving [I/S] on his own with Edwige given his concerns she was feigning unconsciousness, he stated [I/S] was big enough to look after himself. When further asked why, given this, he considered he himself was at risk, he stated he did not think Edwige was not breathing. He thought he had seen her put herself on the floor on numerous occasions, often with her eyes shut. He accepted it was a significant error of judgement to assume she was faking it.

vi. When he came back Edwige was still in the same position and [I/S] had left. When asked if he reassessed his thought that she might be trying to lure him, he said no, he had observed her lying on the floor for long periods of time before. It was also put to him by our counsel that he had not been assaulted when he removed the ligatures, to which he replied that he had been careful not to get too close to her.

vii. He tried to use the oximeter but could not get a reading. He tried on a couple of fingers. He thought the machine was not working. He said he was aware those machines are not as reliable if you have darker skin.

viii. He called for the other nurse, but did not call his pit alarm. **Another nurse** came.

ix. He explained he could not get a reading with the Oximeter machine, so [I/S] went to get a blood pressure machine to see if he could get that to work. At this point Edwige was still not opening her eyes or responding.

x. When he came back, they put the machine on Edwige and attempted to get her blood pressure. They tried this on two occasions but failed both times. They then tried the oxygen saturation machine on **the nurse** as well, and it functioned for him. He realized there was something seriously wrong. He saw discharge coming out of her mouth, and he came to the conclusions he had aspirated and would need a suction machine to clear the blockage.

xi. He confirmed he had still not taken Edwige's pulse by this point. He conceded this was bad judgement on his part.

xii. He told **the nurse** to call a medical emergency at this point, and told him to be specific that they needed a suction machine. A great many people came in response to this, including **[I/S]** who initiated CPR.

xiii. He saw the observation sheet while the ambulance crew were still there. He noticed the 15.45 entry on the sheet was blank, whereas the entries for observations at 16.00 and 16.15 had been completed. He said this was very concerning for him as he realized it probably meant that this observation had been missed.

xiv. His best estimate of the time he first found Edwige was 15.55. His estimation that a medical emergency was called anything up to 7 minutes later. He was informed that a call to the ambulance service was logged as being received at 16.08, but he did not have any recollection of how long it took to call an ambulance after a medical emergency had been called.

xv. When asked if there was anything similar on Colne Ward to the picture of the ligature removed from Edwige, he said he could not think of anything specific on Colne Ward which looked like that. He would conclude it was somebody's clothing.

xvi. He was asked about his witness statement, where he said that from memory Edwige had been in the laundry room on the ward within the hour prior to the incident, and that it was not inconceivable that she removed an item of clothing from the laundry room and used it to obtain the three ligatures. He had said she would have had to have been with a member of staff at the time as there was a locked door which required a key. He stated that given Edwige was wearing strong clothing, there were not too many places she could hide any item of clothing and so any staff member observing Edwige during a visit to the laundry would have to be fairly lackadaisical to have failed to observe her secreting an item of clothing. He agreed if any patient in strong clothing had been able to obtain an item of clothing from the laundry this would be very concerning.

b. The other senior nurse gave the following evidence:

i. A patient knocked and alerted him there was a banging sound coming from the corridor at 15.40, just a few minutes after he came on the ward. He managed to reassure the patient and find the PRN. He asked the patient to come to the medication hatch area to get a key. He knew a nurse was on the ward at the time, and so he looked for that nurse. The patients in the communal area told him he was dealing with the incident of Edwige tying the ligature. He went to get the keys from [I/S] and found him dealing with Edwige.

ii. When he got there, he found [I/S] kneeling down. He also observed one of the patients standing around the corridor. He asked her to move. When he asked what was happening, [I/S] said Edwige had tied a ligature. He had already untied two but was trying to untie the third. He had to run to the office to get a ligature cutter. When he returned, he used the ligature cutters to remove the last ligature.

iii. He then collected the medication keys from [I/S] and left and went to the medication hatch. He stated [I/S] was still with Edwige when he left. When he left, Edwige was still warm and her skin was not pale. There was no sign of any mark to her neck. He thought she was breathing as he heard her cough before he left.

iv. When asked if he said to [I/S] that Edwige was playing, he said this *"never happened*". He stated he was not concerned that Edwige was unconscious, his focus was on the patient he was dealing with as she felt abandoned.

v. When [I/S] evidence was put to him that they both thought there was a case to put her on constant observations, he stated he could not remember having this discussion. When asked if it was likely he thought constant observations would be appropriate, he stated he was unable to say, as this was a decision for the MDT.

vi. When asked if he was part of the MDT on the morning of 3 February, he stated he was and the risk was reviewed and the decision was to keep Edwige's observations the same. When it was put to him that there was no record of this decision, he conceded that there should have been.

80. For me, those two men were the ones who really neglected Edwige and just didn't care. I don't know how they are still working in this type of job after this. The reason you choose to do a job like this is to help patients. They did not help her at all. They are proper nurses. They would known he basic emergency response skills, that if someone has a ligature you call for help and you call an ambulance. There were no right actions that day, none They could possibly have saved her

life, but it seems they were in no hurry to help her and it was not an emergency for them, until they realized she was not breathing and they would be in trouble.

81. The doctors in Basildon Hospital told us it doesn't even take a minute of being deprived of oxygen until the brain stops. When me and my family were hearing this at the inquest, we already knew Edwige was gone by then. It was clear to us that in reality she passed away at St Andrews, when they were trying to measure her oxygen levels and getting no readings.

82. I just don't understand how it can be possible to still think a person is faking being unconscious for such a long period of time, especially once you have used your hands to try and remove a ligature from someone's neck and have had to get cutters because there's one you can't undo. If they were close enough to cut the ligatures off her, they would surely be close enough to check her breathing. It's clear to me that they should have just called an ambulance there and then. The times they checked her blood pressure and nothing, they didn't even call an ambulance or start CPR then. There was just so much neglect. The fact that Edwige was just left on the floor for such a long period of time, unattended for a while, but they still thought she was faking it, it's just so upsetting. It really is a lot to take.

83. I think what happened to Edwige had a lot to do with racism. She was a black girl experiencing mental health issues who was crying for help, but they didn't provide it and instead she was treated as though she was a threat. In particular the assumption that she was faking unconsciousness to lure them to attack them, I see that as racist. I am aware that St Andrews were forced to concede at the inquest that there were no Datix reports of Edwige having done this at St Andrews. I feel like if it was a white person in the same situation, they never would have walked away from that person as they did with Edwige. I don't think how they acted was to do with their lack of training. They all said they had their training. I think they saw her colour and thought, black people are aggressive. When **the nurse** said he left the nurse with Edwige because he thought he could handle himself with her, that looked to me as though he was saying just hand her over to another black man so he could handle her better than himself. Both nurses also made comments about the colour of Edwige's skin as a reason for thinking she was OK, due to her not looking pale or as a reason for not getting a reading on their machine. I find this odd. I don't understand how they can know if she was pale or not; you can't easily see if we go pale or not due to our darker skin colour.

84. I am worried that what happened to Edwige is evidence of a wider pattern at St Andrews. If you read their reviews on the internet they all say the same thing. That staff are just very neglectful of patients. They just didn't care.

85. I feel that all the self-harm incidents in January and February 2020 were a cry for help, and that Edwige must have felt this was the only way for them to listen was for her to keep harming herself, and so she kept doing it. I feel it's clear that she did not want to be on 15 minutes observations, she wanted someone to be with her and to support her because she didn't feel safe. I feel she was telling them this and they just didn't listen. When she ligatured overnight on 2 February, they did not talk to her to comfort her or find out how she was feeling the next day, they just went back to checking on her every 15 minutes. Even if they were short staffed, I don't accept that they couldn't have done this. Even if it's straight after the handover, someone could surely have easily taken just 10 minutes out of their day to check on a patient who had harmed herself the night before. Instead they just stuck her back on the 15 minute checks and left her to handle her crisis on her own. But she was vulnerable. She couldn't do it on her own, she need the support.

86. I am also very concerned by **the nurse's** evidence that he saw Edwige walking around the laundry room on the 3 February, after what she had done the night before. Should there not be tight security for a room like that? Clearly that day there was just none. When we went to visit Colne Ward after Edwige passed away, there were so many doors with security fobs to get through on the way into the ward. However it seems within the ward they just let all the patients walk wherever they want. After the inquest, our family was contacted by one of the patients on the ward who informed us that patients were just allowed to walk wherever they want on the ward. I don't understand how this was allowed to happen, and how Edwige was able to get to the laundry room without anyone seeing if she had anything on her. I am angry because clearly the staff were not all being truthful at the inquest. **The nurse** did not say who he saw take Edwige to the laundry room, and no one else admitted to having taken her there. If a person took her to the laundry room, they are at fault for what happened to her. No one has admitted to that. I think if **the nurse** says he saw her going into the laundry room, surely he could have challenged her or the staff member with her and asked what they were doing? I don't understand why he couldn't have just stopped her if he saw her there.

Training

Did you have any concerns regarding the training, ability or conduct of any members of staff on the ward at any time? Again, please provide as much detail as possible to help the Inquiry to understand your observations. For example:

a. What were those concerns? To whom or to what events did they relate?
b. How did the matters you were concerned about come to your attention?
c. When was that?
d. Over what period?

87. I have concerns about the training and ability of staff at St Andrews in responding to medical emergencies. I have been reminded that during the inquest, all staff members involved in the emergency response 3 February 2020 confirmed they had received Basic Life Support training.

However, the resuscitation expert at the inquest [I/S] stated at the inquest that basic life support steps were not following by the first responders to find Edwige on 3 February. He stated that the basic emergency response steps that needed to be followed when finding a patient with a ligature were to check the area for safety, check for a response from the patient, then to remove the ligature, then check if they were breathing, and thereafter to call for an ambulance. He stated he would expect any staff finding a patient with a ligature to have removed the ligature within a minute of finding the patient and to have called for an ambulance within 2 minutes. He said he saw no reason why the staff who found Edwige on 3 February did not immediately check for her breathing and no justification why an ambulance was not called within 2 minutes of finding her.

88. I want to know why the nurses who found Edwige on 3 February didn't follow their training. Basic life support training is something they should all know. They all had their proper training but for some reason they didn't follow it. They should have been experienced in handling patients in that context who were doing this sort of thing. For me, I always have to sign off on my training before I go into my placement. In my experience, basic life support training is something that everyone knows about in a hospital. If you are signed off on life support training, then it allows you to go out and do life support. I just don't understand how it can take them over 10 minutes to call an ambulance after finding Edwige. They will know it has to be called within 2 minutes. For us in our hospital, if we find a patient in danger we immediately shout for help until someone comes along. If we can't do it, someone will take over who can. I am shocked that no one shouted for help, checked her breathing, called an ambulance or used their radio to call for help. It seemed they were all standing around in shock and didn't know what to do.

89. I also understand from the Psychological Approaches investigation that front line staff had not received the nationally approved advanced training for working with women diagnosed with a personality disorder, called Women's Knowledge and Understanding Framework (WKUF+). I find this concerning that staff were not even properly trained in handling the main type of illness that Colne Ward was there to treat.

After Edwige had died

In your application for core participant status, you explained that Edwige was taken to Basildon University Hospital and that you were informed that she had suffered a hypoxic brain injury which she would not recover from. We understand that Edwige sadly died on 5 February 2020. Is there anything that you would like to tell us about how you were informed that Edwige had died?

What were you told, if anything, about processes that would take place (for example internal investigations or an inquest) and how matters would be handled?

Was any support offered to you (and/or to other family members and friends) after Edwige died, either in the immediate period after she died or at a later stage? If it was:

a. Who offered that support?
b. What was it? What did it consist of?

c. *When was it offered?*
d. *Did you take up any support offered?*

Do you have any comments, concerns or observations in relation to how you were communicated with, treated and supported after Edwige died?

90. My mum and dad attended Basildon Hospital the most on 3 February and in the following days. I will quote from my mum's inquest statement about this period:

> *'47. On Monday 3 February 2020, I took my children to school and returned home and started to cook. I planned to call Edwige around 8pm. At approximately 6:30pm I began to feel very ill. My husband told me to sit down and rest. Within a few minutes I heard a heavy knock on the front door. Flavien went to look and saw a police car. Flavien and I went to answer the door. The police told us something had happened to Edwige. They took us to Basildon Hospital with the sirens on.*
>
> *48. At the hospital, we met a man and a woman who told us they were from St Andrews. The man was crying and I noticed his eyes were very red. He said "I'm sorry ma'am" and I asked him what happened. The lady said "No she's OK, the doctor is working on her. Just wait here."*
>
> *49. At 10pm, after I had been at the hospital for 2 hours and nobody had told me anything, I went to find out for myself. I told one of the hospital staff that I was Edwige's mum and needed to know what had happened to my daughter. I was told that Edwige was in intensive care and a doctor would come and see us. Eventually I spoke to a doctor who told us that Edwige had a brain injury. She was breathing via a machine but if they were to take her off she would pass away.*
>
> *50. I asked the man who was crying and saying sorry earlier if he had been living with Edwige and if so what happened. He said, 'she asked to go and have a shower and when they found her she had hung herself with* **an item** *However, the doctor later told me that Edwige had used a* **a different item and showed it to me.** *. I was told St Andrews had tried to resuscitate Edwige for 45 minutes, but realised she had a brain injury. I was told Edwige was still breathing when she was transported in the ambulance.*
>
> *51. When me and my family were finally allowed to see Edwige she was in a coma and surrounded by life support machines. I was told again by the doctor that the*

machines were the only thing keeping her alive. I did not see any marks around her neck but I did notice many bruises and cuts on her arms and dried tears on her face.

52. We saw her again at 7am the following morning. I was trying to speak to her and be close to her, saying I would pray for her and I loved her. There was an odour coming from her as though she had already died and was decomposing. Everything was yellow in her body, and I could see no life in her anymore.

53. At around 11am, a doctor spoke to our family in his office and explained that Edwige's brain damage had been there for 24 hours, which meant she would be very disabled: she would be blind, and unable to talk and move. He said because of all this damage, if we loved Edwige the best thing to do would be to take her off the machines and let her go in peace. As a family, we agreed to follow the doctor's recommendation. We asked them to wait until we came back in the evening to switch off the machines, so everyone could see Edwige one last time. We thought we had agreed this with them. We went to leave the hospital. Before we even got to the lift, the hospital staff told us back to say that Edwige had passed away.'

91. I think the next day when my mum came home, she told us Edwige was in hospital, and that they had put her on machines that were breathing for her. We went to the hospital, and we saw her. The doctor came out and told us she was not going to make it, and that it was best to take her off the machines. My mum asked if they could at least give her an extra 24 hours. I remember going downstairs in the hospital and there were St Andrews people there, who were crying and saying they were sorry. There were some people who apparently knew what had happened. One person told us Edwige had taken a shower and that she probably hanged herself after the shower. We were confused when we later went to visit her room as we could see there was nothing there she could have hung herself with. Another woman who had been crying asked if she could speak to us privately. It was all very confusing. One person said he would give us his address so he could tell us something. All the St Andrews staff at the hospital looked afraid. After Edwige passed away, we heard nothing more from any of these St Andrews staff members.

92. There was a woman called **[I/S]** from St Andrews who became our only point of contact for St Andrews after Edwige died. She came to the house with a doctor and the police soon after Edwige died. I think it was the police who told us what had happened. The only details they gave us was that they had found Edwige with a ligature and then they had started CPR for a long time.

93. The doctor gave my mum a bag with some of Edwige's stuff, although there were a few things missing. She always kept a diary, which we never saw.

94. [I/S] said she would take care of us. She told us they could show us Edwige's room, and they would fund all the funeral expenses. [I/S] thought it was going to be just between us and them directly. She did not think we would go to solicitors. She told us just go through them if we needed anything. She wanted to keep it just between us and the hospital. There was a time when I was telling my mum this wasn't right and that we would have to find our own legal advice. The only support we got from St Andrews was that they were going to fund the funeral. After we contacted solicitors, [I/S] stopped contacting us or giving us any direct support.

95. We did not want their support. We just wanted to be left alone as a family. They did not want to be involved in Edwige's case when she was alive. After she has passed away, all of a sudden they want us to get involved. We just wanted to grieve as a family.

Other investigations or legal proceedings

After Edwige died, were any investigations undertaken by or arranged by the Trust or any other relevant mental health provider?

If so, please tell us what you know about any such investigation, including:

a. *By whom was the investigation carried out?*
b. *Was the investigation undertaken promptly?*
c. *How long did it take?*
d. *To what extent were you (and/or other family members or friends) involved in or updated about the progress of the investigation?*

What was the outcome or the findings of the investigation? For example:

k. *Were any failings identified? If so, what were those?*
l. *Did you agree with the findings?*
m. *Was a report produced? (This might be, for example, a Root Cause Analysis or Serious Incident report).*
n. *Was a copy of the report provided to you?*
o. *What were your impressions of the report in terms of both its findings, and its adequacy and accuracy?*

96. I remember hearing from our solicitor at the time that St Andrews were arranging an investigation into Edwige's passing.

97. We met with the investigators on 23 June 2020 with our solicitor and interpreter present to answer their questions about Edwige's background and to let them know our concerns and questions. They explained they were from a company called Psychological Approaches and they had been commissioned by St Andrews to conduct an independent review into the circumstances of Edwige's death. When they finished their review on 30 October 2020, we met with them again with our solicitors and an interpreter and they explained their findings. They also sent a copy of

their report to our solicitors, which was translated into Lingala for my parents several months later. The main findings of their report are referred to earlier in this statement, and with which I now agree having seen the evidence at Edwige's inquest.

98. One thing that did always bother us was the fact that no CCTV was ever provided from Colne Ward. When we were allowed to visit the ward after Edwige passed away, we all noticed there were cameras on the ward. I noticed one in the living room area, and one facing all the way down the corridor to Edwige's bedroom. However when our solicitors requested CCTV from St Andrews they were told that none existed as there was no CCTV on the ward. None of us were satisfied with this answer. To this day, we have been given no explanation of what the cameras were that we all saw when we visited the ward.

99. I think the PA investigation could have happened sooner. We were interviewed 4.5 months afterwards. I don't know why it took so long and wonder if it was because St Andrews didn't give the police everything.

Other investigations or legal proceedings

What were you told about the process for any external investigation into Edwige's death?

From whom did you request or receive that information?

What level of involvement did you (and/or other family members or friends) have in any such investigations or legal proceedings?

100. I have been reminded by my solicitor that the Care Quality Commission conducted several inspections of St Andrews Essex in February 2020 after Edwige died and their inspection report dated 12 May 2020 found the hospital did not have enough registered nursing and support staff to keep patients safe and staff did not always assess and manage patient risks.

101. I am aware that Essex Police conducted an investigation into Edwige's death on behalf of the Coroner. I recall from the Inquest that the police investigator, **[I/S]** confirmed that the police were first called by St Andrews several days after Edwige died. My solicitor has reminded me that he said they were contacted on the 7 February 2020. I don't get why it took such a long time for St Andrews to call the police given the incident happened on 3 February and Edwige died on 5 February. **[I/S]** was in contact with us from the day after she died, so we do not understand why the police were not contacted at that point. Someone must have told the police to collect my mum on 3 February, so we do not understand why they did not investigate what happened from then.

102. I have been reminded by my solicitor that the police concluded after their investigation that there was no willful neglect, gross negligence, or no third party involvement in Edwige's death, and that this information was given to us during a meeting at our home with our solicitor present on 19 August 2020. After having seen the evidence of what happened to Edwige at her inquest, I find it hard to understand how they could have concluded there was no willful neglect of Edwige.

103. In around August 2021, our lawyers were informed by the Coroner that a safeguarding adults review into Edwige's care was being undertaken by Essex Safeguarding Adults Board (ESAB). They wanted to meet us about Edwige's care. However a meeting was not actually arranged until March 2022. At the first Pre-Inquest Review hearing of Edwige's inquest on 11 March 2022, the Coroner criticized ESAB for the delays in their preparation of the SAR report. This was after ESAB had informed her they were having to change the author of the report as the original author did not have sufficient skills to prepare the report. The Coroner told them at the PIR that their delays were unacceptable and holding up the inquest.

104. We had a meeting with the new SAR report author on 24 February 2022. He wanted us to share our concerns and tell him our account of what happened to Edwige, which was difficult for us as we had already had lengthy meetings with our solicitors and the investigators from Psychological Approaches where we had been required to give the same information and concerns. At that meeting the SAR author said he would share a draft of his report with us before finalizing it. However, we did not hear from him again and on then on 15 July 2022 the Coroner told our solicitors she had received the final SAR report from ESAB.

105. The SAR report contained a summary of Edwige's care from after she had been taken from our home by social services. This was the only time we have been given any details of what happened to Edwige after she was taken by social services until she arrived at St Andrews. My solicitor informs me that this period was outside the scope of the inquest.

106. When the SAR report was provided to us, we did have concerns about the section of the report covering Edwige's time at St Andrews. It seemed they were trying to downplay the failures by St Andrews, which were already clear to us from the witness statements and Psychological Approaches report we had received. I am concerned that their report relied on misleading information from St Andrews which meant their conclusions in respect of Edwige's care at St Andrews were too lenient.

107. The SAR report dismissed concerns about the 15.45 entry on 3 February not having been completed. It stated that someone from St Andrews had explained that this entry was in fact correct and this observation did take place. Our solicitor raised our concerns about this with ESAB at a meeting on 26 July 2022, which were that the nurse who had said he completed the 15.45

entry stated he had made this observation after Edwige had been found with a ligature and that this was not consistent with other evidence that she was found at 15.55. Our solicitor has reminded me that he questioned whether St Andrews had breached their duty of candour. At this meeting ESAB said they would look into this and gave us the impression they would take these concerns seriously, but after the meeting they sent our solicitor an email saying their investigation was completed and they would not be making any changes to the report.

108. Their report also contained several other conclusions on St Andrews' care of Edwige which we didn't think made sense at the time and make even less sense now we have heard all the evidence at the inquest. The report refers to the decision of the second nurse to find Edwige **[I/S]** to leave Edwige unattended the floor on 3 February 2020 as reflecting clinical reasoning, as he thought he could observe Edwige breathing and was dealing with another incident which required more urgent attention. I now understand that the other incident he left Edwige to attend was another patient requesting medication. Both nurses also confirmed at the inquest that they hadn't checked if Edwige was breathing at this point, and the second nurse only believed she was breathing because he thought he had heard her cough. I do not understand how it could be justified to leave a patient on the floor with a tight ligature round her neck if they not even checked if she was breathing or her pulse. The resuscitation expert **[I/S]** gave evidence at the inquest that neither nurse's actions were in accordance with basic emergency response training. I do not understand how the SAR report could have reached the conclusion that there was clinical reasoning to leave Edwige unattended on the floor in this situation.

109. The SAR report also stated that it was justified for nurses to think Edwige was feigning unconsciousness on 3 February, which I find shocking. Their report refers to a ligature incident in the records on 23 January 2020 as justification for this. It says the notes for that incident state Edwige had ligatured and appeared unresponsive on the floor but later state that her presentation was in keeping with emotional distress. The report concludes that it can be implied from this Edwige had never been in physical danger. My solicitor has pointed me to the note of this incident in Edwiges records, which says that after ligaturing Edwige had been placed in the recovery position by staff and had proceeded to have what appeared to be a non-epileptic fit. I have also been reminded that St Andrews were forced to accept during Edwige's inquest that there were no Datix reports or other notes in Edwige's records from St Andrews which reported that she had ever feigned unconsciousness to try to attack staff while at St Andrews.

110. I do not think the SAR author considered records properly in reaching his conclusions. I am concerned that he may have been given misleading information by St Andrews through the SAR process which has led to these conclusions. I would like this to be investigated by this Inquiry, and to see the contribution St Andrews made to the SAR which ESAB refused to share

with us. I am concerned that St Andrews used their SAR response as a means of influencing the outcome of the inquest.

Family experience at the inquest

111. The inquest was held before Area Coroner Sonia Hayes from 12 June 2023 - 23 June 2023 at Essex Coroner's Court.

112. St Andrews were very aggressive during the inquest and during the Pre Inquest Review hearings, including towards us as a family, even though most of their staff's failings had been identified in the Psychological Approaches report which, after a long delay, they said they had accepted. St Andrews had initially approached the inquest seeking to deny any wrongdoing despite being advised by the Coroner at the first Pre Inquest Review Hearing to take advice on making admissions as a result of the failures identified in the PA report. They did not make any admissions until just before the inquest was about to start. The admissions they made were very limited and covered almost none of the failures highlighted in the PA report. When pressed they were forced to confirm they did not admit to anything which had caused or contributed to the death.

113. In the months before the inquest, St Andrews also sent us witness statements from several staff members which they had taken from their staff for the purpose of the inquest. Several of the statements contained the same allegation as had appeared in the SAR report that Edwige would ligature or feign unconsciousness in order to lure staff to attack them. It felt like this was part of their strategy at the inquest, as they also tried hard to get the SAR report admitted as evidence for the inquest. When a witness **[I/S]** mentioned this at the inquest and it was challenged by our legal team. St Andrews were forced to concede that there was nothing in the records to support that Edwige had done this during her time at St Andrews.

114. The witness statements we received from St Andrews before the inquest included a statement from **[I/S]** who was Edwige's Responsible Clinician until she left to go on maternity leave August 2019. Our legal team objected to this statement being referred to at the inquest as it contained observations about Edwige having suicidal intent during her death, which was months after this witness had gone on leave. The statement also contained multiple references to the SAR which our legal team thought was an attempt to get the SAR admitted as evidence by the Coroner, when it largely covered events that were out of scope. The Coroner agreed not to include this witness statement in the inquest evidence.

115. St Andrews also made submissions before the inquest arguing that mum should not be allowed to give a witness statement covering our family's experience of how Edwige had been taken away from us by social services, or that if she were then the SAR should also be provided to the jury which they said would contradict my mum's account. Our legal team argued the SAR was largely dealing with events outside of scope of the inquest and there was no need to exclude any of my mum's witness statement. The Coroner agreed, and my mum's statement was admitted in full whereas the SAR report was excluded.

116. It felt like St Andrews were trying to paint us as the bad people. They wanted to paint us as if we neglected Edwige. It was hurtful. Edwige always wanted to come home. She did not want to tell us what she was struggling with. If we had known, we would have found a private hospital for her. We would have done anything. We believed we had no rights to her. Social services told us she had no rights and my parents had no rights. We were scared and didn't know what we were or weren't allowed to do. We never got calls from social services to update us. Edwige was the only one to update us when she can.

117. The jury gave their conclusions at the inquest on the last day it was listed for. The Coroner said she was going on holiday the following week and so she asked us to provide written submissions on PFD reports on a date after the inquest. I understand our lawyers made submissions arguing for a PFD report and St Andrews argued against one. Our submissions were that there remained concerns in respect of:

a. Whether observations were in fact carried out at irregular intervals and were conducted as "meaningful interactions" rather than simply physical checks on a patient's location;

b. The use of observations in order to mitigate a patient's risk of suicide or self harm;

c. The adequacy of St Andrews' training and policy to ensure all staff are aware of the risks of ligature tying.

118. We never received any decision from the Coroner. When our solicitors chased the Coroner's officer about this several months later, they were just told there would be no prevention of future death report and no explanation was given for this. I am concerned that our submissions were not properly considered by the Coroner and that there was not a reasoned decision on this issue. I consider there were good reasons for a prevention of future death report to be made.

Personal impact

119. Edwige's death has impacted me a lot. There are days when I can't concentrate. There will be days when I will be watching something that triggers me or makes me think of her. I could be walking and then will start thinking of her. Even when I started at University, I was wondering whether Edwige would have gone, which Uni, what subject she would have done, what career she would have. Her death has impacted me in every way.

120. After hearing what happened to her at the inquest, I was thinking at first that I don't want to do nursing anymore. But then I thought there has to be a change. The testimony I heard was so shocking. I decided to stick with my course as I want to make a difference, especially in improving the health outcomes for black people. I hope I can make a change for someone when I become a nurse.

Recommendations for change

Are there any recommendations that you think the Chair should be considering making at the conclusion of this Inquiry?

What changes would you make to any part(s) of the mental health system, or to the system as a whole, in order to bring about lasting and meaningful improvements?

121. I think the Inquiry should make a recommendation for it to be a mandatory requirement for all hospitals to have a safe level of staffing. If there is not enough staffing, they should always have replacement options and a plan in place. If someone goes on leave, it should not take up to six months to replace them. If this happens, hospitals like St Andrews shouldn't be given the contracts to run these services. If they can't manage it, they should shit the place down. If they don't have safe staffing levels at a hospital, they shouldn't transfer more patients there. They should only have allowed patients to be admitted there where they had the resources to deal with all the patient's needs.

122. The Inquiry could also make a recommendation to make sure that all staff are properly trained and drilled for first aid, and are properly trained to understand the patients they work with.

123. Finally I am very concerned that the staff member from Oaktree Manor who Edwige made allegations of sexual assault against could still be working, and want to know if there is anything the Inquiry can do about this.

Documents

124. I understand my solicitors have the following documents which can be made available to the Inquiry:

	Document title	Date
	Inquest Bundles	
Bundle 1 – Witness Statements		
1.	Statement – [I/S]	26/02/2020
2.	Statement – [I/S]	21/12/2020
3.	Statement – [I/S]	26/02/2020
4.	Initial Account – [I/S]	04/02/2020
5.	Statement – [I/S]	27/04/2020
6.	Statement – [I/S]	26/11/2021
7.	Statement – [I/S] – emailed	04/201/2020
8.	Statement – [I/S]	26/02/2020
9.	Statement – [I/S]	13/12/2020
10.	Initial Account – [I/S]	06/03/2020
11.	Statement – [I/S]	06/03/2020
12.	Initial Account – [I/S]	03/02/2020
13.	Statement – [I/S]	06/03/2020
14.	Statement – [I/S]	26/06/2020
15.	Statement – [I/S]	05/12/2022
Bundle 2 – Reports and Exhibits – Redacted		
16.	Psychological Approaches CIC – Redacted	16/11/2020
17.	CQC Focused Inspection Report – Redacted	19/05/2020
18.	[I/S] – Hertfordshire NHS Trust – Redacted	29/06/2020
19.	Social Care Report – [I/S] – Redacted	21/10/2020
20.	Coroner's Report – [I/S] – Redacted	Undated
21.	Care Plan 111219(1) – Redacted	22/07/2019 – updated 11/12/2019
22.	Care Plan 111219(2) – Redacted	22/08/2019 – updated 11/12/2019
23.	MDT Care Plan – Redacted	Last updated 11/12/2019
24.	Positive Behaviour Support Plan - Redacted	11/12/2019

25.	Seclusion Management Care Plan 220119 – Redacted	22/01/2020
26.	15 mins obs sheet – Redacted	03/02/2020
Bundle 3 – Medical Records – St Andrew's Hospital – Redacted		
27.	Section A: Pre-St Andrew's Admission Records	30/11/2015 – 25/03/2019
28.	Section B: MHA Documentation	06/04/2016 – 24/07/2019
29.	Section C: Assessments and Care Plans	22/01/2019 – 13/01/2020
30.	Section D: Observation Documentation	08/01/2019 – 22/01/2020
31.	Section E: RiO Progress Notes	08/04/2019 – 03/02/2020
32.	Section F: Physical Healthcare	01/04/2019 – 24/01/2020
33.	Section G: Risk Documentation	09/04/2019 – 13/01/2020
34.	Section H: CPA Documentation	13/08/2019
35.	Section I: Medication Documentation	01/02/2020 – 04/02/2020
36.	Section J: Misc Clinical Documents	01/04/2019 – 01/02/2020
37.	Section K: Policies and Procedures	01/08/2019 – 01/03/2020
38.	Section L: Training Records	25/02/2020
39.	Section M: Ward Plan	Undated
40.	Section N: Ward Documentation	24/07/2019 – 03/02/2020
41.	Section O: Incident Documentation	04/02/2020 – 26/02/2020
Bundle 3A – Medical Records		
42.	Basildon A&E Notes	08/05/2019
43.	Recovering Quality of Life questionnaire	10/06/2019
44.	Positive Behaviour Support Plan – St Andrew's Healthcare	Last updated 11/12/2019
45.	Care Plan	22/07/2019 – updated 11/12/2019
46.	Care Plan	22/08/2019 – updated 11/12/2019

47.	STAH Multidisciplinary CPA Treatment Plan	08/10/2019 – last updated 11/12/2019
48.	Seclusion Management Care Plan	21/01/2020
49.	Positive Behaviour Support Plan	21/08/2019 – 08/02/2020
50.	(Colne) CPUM Current Evaluation	08/01/2020
51.	Colne START form	13/01/2020
52.	RiO Progress Notes	27/01/2020 – 05/02/2020
53.	Colne Handover Sheets	01/02/2020 – 05/02/2020
54.	Datix Safeguarding Log	12/04/2019 – 03/02/2020
55.	Datix Incident Reporting	09/04/2019 – 03/02/2020
56.	Datix Seclusion Log	10/08/2020
57.	Datix Incident Reporting	09/04/2019 – 03/02/2020
58.	Datix Seclusion Log	10/08/2020
59.	Rio Notes	08/04/2019 – 27/01/2020
60.	15 Minute Observation Sheet	20/01/2020 – 02/02/2020
61.	15 Minute Observation Check Sheet	03/02/2020
62.	**Bundle 4 – Basildon Hospital Records**	Various
Bundle 5 – Policies and Procedures		
63.	Appendix 1 – Resus-Response-Matrix-V49	26/10/2022
64.	Appendix 10 – Anaphylaxis algorithm 2021	2021
65.	Appendix 11 – Adult Choking Algorithm	2021
66.	Appendix 2 – Medical Emergency Bag Handover and Checklist Sheet V3	Undated
67.	Appendix 3 – Post Resuscitation Report Form	Undated
68.	Appendix 4 – Resus-DNACPR-recreated	Undated
69.	Appendix 5 – Resus-Life Extinct Record Sheet	Undated
70.	Appendix 6 – Resus policy post-death process	Undated
71.	Appendix 7 – Adult Basic Life Support Algorithm	2021
72.	Appendix 8 – In-hospital Life Support Algorithm	Undated
73.	Appendix 9 – Adult Life Support Algorithm	2021

74.	Appendix A – LRP – Definitions in MHDS	Undated
75.	Appendix B – LRP – Incident Debrief Process	Undated
76.	Appendix C – LRP – Post Incident Debrief of Service Users Version 2.0	Undated
77.	Clinical Risk Management Policy (CRM 02) v8.2	February 2015
78.	Clinical Risk Management Policy v1.2	August 2022
79.	CRM 26 Positive and Safe Policy v8.4	January 2016
80.	CRM Inpatient Procedure v1.1	September 2021
81.	Document 5 – Constant Observations Record Completion Flowchart	Undated
82.	Enhanced Support Policy v1.0	August 2019
83.	Enhanced Support Policy v2.1	March 2023
84.	Enhanced Support Procedure v1.0	August 2019
85.	Enhanced Support Procedure v2.4	March 2023
86.	Enhanced Support Responsibility Accountability	July 2020
87.	Enhanced Support Spot Check Procedure v1	July 2021
88.	Least Restrictive Practice Policy v1.0	October 2019
89.	Least Restrictive Police v1.2	December 2022
90.	Positive and Safe Policy v1.0	November 2021
91.	Positive and Safe Procedure v1.0	November 2021
92.	Resuscitation Policy (CRM 16) v13.1	December 2017
93.	Resuscitation Policy v1.0 – downloadable documents	November 2022
94.	Resuscitation Policy v1.0	June 2022
Addendum Bundle A - Redacted		
95.	Datix form	21/01/2020
96.	Datix form	22/01/2020
97.	Datix form	23/01/2020
98.	Datix form	26/01/2020
99.	Datix form	27/01/2020
100.	Datix form	28/01/2020
101.	Datix form	29/01/2020
102.	Datix form	02/01/2020

103.	Statement from [I/S]	11/04/2023
104.	Second statement from [I/S]	19/04/2023
105.	Family submissions on PIRH	12/04/2023
106.	Statement of [I/S]	12/04/2023
107.	Dramatis Personae	
108.	St Andrews inquest admissions	19/04/2023
109.	St Andrews submissions	13/04/2023
	Pre Inquest Review Hearings	
110.	PIRH Agenda –	25/10/2022
111.	Coroner's Note of PIRH	19/10/2023
112.	Coroner's Note of PIRH	30/04/2023
113.	Coroner's Note of PIRH	26/05/2023
114.	Coroner's Note of PIRH	31/05/2023
	Other Inquest Documents	
115.	Agreed Jury Chronology	Undated
116.	List of relevant individuals	Undated
117.	Pen Portrait (Joyce Nsilu Witness Statement)	Undated
118.	[I/S] Witness Statement – Redacted	10/05/2023
119.	[I/S] Witness Statement	28/04/2023
120.	Record of Inquest	23/06/2023
121.	Family's PFD submissions	03/07/2023
122.	St Andrew's PFD submissions	10/07/2023
123.	Email from Coroner's officer on PFD report	31/01/2024
	Reports	
124.	[I/S] Safeguarding Adult Review	July 2022
125.	Psychological Approaches Review	16/11/2020

Statement of truth

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

I am willing for the statement to form part of the evidence before the Inquiry and be published on the Inquiry's website

SIGNED: **[I/S]**
Docas Nsilu

DATE: 24 June 2025