Name of witness: Lynne Breaker-Rolfe
Statement No: 1
Exhibits: Appendix 1
Date:13.11.2025

LAMPARD INQUIRY

WITNESS STATEMENT OF MS LYNNE BREAKER-ROLFE

I, **MS LYNNE BREAKER-ROLFE**, date of birth [I/S] of [I/S] [I/S] will say as follows:

1. I make this statement pursuant to a Rule 9 request for evidence received from the Lampard Inquiry dated 29th January 2025, in relation to treatment provided to my late husband, Roy Breaker-Rolfe, whilst under the care of Essex Partnership University NHS Foundation Trust. Roy was born on 19th April 1957, and passed away on 21st February 2021, aged 63.

2. This statement is made from my own memory of events, knowledge and belief. I have also had sight of various documents and reports which have assisted me, I have listed these documents in an appendix and spreadsheet attached to this witness statement. Roy's GP records have assisted me in writing this witness statement, however I have not had sight of a complete set of Roy's medical records from Essex Partnership University NHS Foundation Trust, the Coroner's file and the Police file, which I would like sight of.

History of Roy's Illness

3. Roy first became unwell around the time that his father died in 2006, although he had always suffered with low self-esteem and anxiety from when I first met him in [I/S].

4. Roy first came into contact with mental health services in 2006 / 2007 through talking counselling in Braintree. The circumstances that first led to this contact was Roy developing paranoia and not being able to sleep.

5. Other than having talking counselling, Roy did not seek any help until 2017.

6. A diagnosis was not given until February 2021. Roy was given two diagnoses': the first was Major Manic Depressive Ill Accompanied by Psychosis and Paranoia. The second, Anxiety Disorder with Adjustment Disorder and Dependent Personality Traits. I felt that the first diagnosis was much more in keeping with Roy's symptoms. Roy was given these diagnosis' as an inpatient at Southern Hill Hospital, Norfolk, by **Doctor A**

7. Roy died 20 days after being released from Southern Hill Hospital, an independent mental health hospital in Norwich, where he was a sectioned patient. Roy was not sectioned previously after attempts to take his life, they were not taken seriously, and the hospital did not listen to what I had to say. Roy did not undergo any other mental health assessment that led to an inpatient admission, care or treatment.

8. Roy had four purported mental health assessments in total between 2017 and 2021.

<u>August 2017</u>

9. In August 2017 Roy was suffering with poor sleep and paranoia. Roy took an overdose and cut his wrists on the 6th August 2017. Roy was taken to Broomfield Hospital A&E department by ambulance and was 'assessed' by a staff member from the Linden Centre, I believe this was more of a question-and-answer conversation. Whilst at Broomfield Hospital A&E, I was asked by the mental health nurse a couple of questions about what happened. I was told that Roy would be referred for mental health help, when I enquired when this would be I was told in about 5-6 months. This was too long for Roy to wait. There were no other next steps put in place, from Roy's GP records it is noted that he was "*discharged – follow up treatment to be provided by General Practitioner"* and that he was *"awaiting crisis team"*; I do not recall any follow up being made with the crisis team.

10. EPUT wrote to Roy's GP on the 7th August 2017 requesting a follow up appointment with Roy within a week.

    "Dear Doctors,

My colleague [I/S] *Senior Community Psychiatric Nurse assessed Mr Breaker-Rolfe in Broomfield A+E on Sunday 6th August 2017. Mr Breaker-Rolfe had self harmed but not with any intention of taking his life. He appears to have long term sleep issues, work place stress, physical health issues including Tinnitus and has started to have racing and ruminating thoughts, misperceptions of noises and activity outside his house at nights leading to some paranoia. Can you prescribe some Quetiapine 25mg nocte and review after 2 weeks please. If symptoms persist continue with 25 – 50mg nocte. If symptoms are reducing considerably, use 25mg nocte PRN."*

Roy's GP did follow up with an appointment on 14th August 2017, which I was present for. This appointment concluded that Roy continued with rev 3m and Quetiapine 25mg was re-prescribed.

11. Due to the referral wait for EPUT's mental health help being too long for Roy to wait, I took Roy to The Oaks, a private hospital in Colchester, around the same time, in August 2017. I believe Roy was still taking the Quetiapine when he saw **Doctor B** at the Oaks. Roy stopped this medication due to having heart flutters. I am unsure on the date this stopped and have been unable to contact **Doctor B** secretary to get this information. However, from memory I believe it to have been around 2019.

<u>September/October 2020</u>

12. On 8 September 2020 Roy became totally paranoid thinking people were in our house and garden and came to do something nasty to him. He would not allow me to get out of the room we were in; he had taken my crutches that I was using after having had a hip replacement. I had to call my son, Byron, to come over. When Byron arrived it took about 15 minutes for Roy to allow him into the garden and house, he dragged Byron upstairs to look for the people who were up there, obviously there was no one there. We managed to calm him down, then he started to say his chest hurt and was having a heart attack and wanted to call the police. I called 999 for the paramedics, they arrived and took Roy to Broomfield Hospital A&E at around 11pm. I told the paramedics that he was not medically unwell, he was in a mental health crisis. They acted as if they did not believe me. They left Roy in A&E by himself. He was calling me to ask where he was and why.

13. Roy was examined at Broomfield Hospital A&E department by a doctor. However, he was not seen by anyone from the mental health team, nor was any information taken from him. He was discharged at 03:07am and allowed to leave on his own with no medication or next steps in place. My son found him wandering along a busy road and he presented very confused and agitated. Broomfield Hospital A&E did not recognise a mental health crisis, I am sure they did not care to be honest, and again they did not listen. Roy's GP records note that the treatment he was given at Broomfield A&E was him being "*reassured*". Additionally, it was asked by Broomfield to Roy's GP for them to repeat a liver function blood test in two weeks.

14. I believe this was the beginning of a long, drawn-out mental health crisis. Roy never recovered fully after this incident. Had they started to treat him then who knows what the outcome may have been for Roy.

December 2020

15. On the 16th December 2020, Roy went missing in the middle of the night, he came back covered in mud, with hardly any clothes on, he had broken his teeth and lost his phone. We did not call any emergency services as he was coming out of psychosis and appeared fine. If Roy had not returned when he did, I would have called 999. However, I knew that calling the emergency services would have been very stressful to Roy, especially having them turning up at the caravan site in the early hours of the morning, so I waited and kept calling his mobile until he returned. The incident on 16th December was relayed to all emergency services on the 17th December 2020.

16. I then left for work, and Roy was asleep.

17. On the 17th December 2020 at around 12 noon, Roy had a major incident. He had tried to strangle himself, he had cut his wrists, climbed an unused water tower and was saying he was going to jump. It took negotiating for 5 hours to talk him to come down.

18. The Street Triage team and the Police both sought an assessment of Roy. I am unsure who the Street Triage team report to, however they watched Roy up the tower for 5 hours and made an assessment that Roy should be detained. They asked the police to arrest him and take him to a place of safety. The Street Triage

team knew and witnessed the crisis Roy was in; Nurse A a Street Triage Nurse, wrote to Roy's GP on 6th January 2021 stating that the *"Police wanted to detain Roy on a Section 136 due to the high risk and Roy's confused presentation and the fact that he had no idea how he ended up on top of the water tower. ST agreed."*. It was evident the Roy was in crisis.

19. Roy was taken to Broomfield Hospital under Section 136 by the Police and was advised by the Street Triage team.

20. There was no bed availability at Broomfield Hospital, and so Roy was taken to the Derwent Centre, at Princess Alexandra Hospital in Harlow. Roy was assessed the following morning, 18th December 2020, at 10:30am due to the doctors working 9 am to 5pm shifts. He was assessed by Dr [I/S] Doctor C Dr [I/S], Dr [I/S] and [I/S]. The next day was too late to assess him, he was out of his psychosis by then.

21. Following this assessment the Derwent Centre asked Roy if he would stay on the ward as a voluntary patient, which he refused. This really confused us because if he was found to be suffering enough to stay on a ward at his request then why was he not found ill enough to be sectioned?

22. Again, no family member was present with Roy during this assessment, however a doctor at Broomfield Hospital did contact me to ask what had been happened; no one from Princess Alexandra Hospital, in Harlow would take my call to tell them. Following this assessment, Roy was referred to Home Treatment Team. Someone visited on 20th December 2020 and took some notes. Roy was referred for counselling support, and carers support was to be put in place for myself. The support was never spoke about again and I never received any calls or support.

23. On the 21st December 2020 the West Essex Home Treatment Team offered support which Roy declined stating that he had enough support at home, and so he was discharged from the service. I was present whilst this telephone conversation took place, Roy controlled the conversation to imply that no further support was needed. I did not really have a say as it was difficult with Roy present to speak negativity about him, so rightly or wrongly I went along with him always believing that it would not happen again. When Roy came out of his episodes, he believed he could continue to remain stable so did not come across as a person in any mental health issues. He was also determined not to be

placed in hospital and so lied saying he had enough support and did not need the Home Treatment Team.

24. On the 23rd December 2020, I spoke to Access and Assessment Services (AAS) asking from medication to be sorted out before Christmas as Roy was not sleeping again. Roy was prescribed Olanzapine 2.5mg to be taken at night. A CT scan and bloods were to be carried out after the new year, which never happened.

25. On the 11th January 2021, we were supposed to have an in-person outpatient appointment review, however it was changed to a telephone call with an AAS doctor. This telephone call resulted in Roy's care being discharged back to his GP. The change in this appointment was a dreadful mistake as Roy lied on the phone telling them he was fine, when he was not. I could not contact anyone to speak to them as I was never given the contact details for this department; Roy would get text messages regarding these appointments. The notes from this meeting state:
"I called him for follow up on 11/01/2021 and he stated that he felt much better and his head more clearer. He stated that he would like to continue medications.
Plan:
    1. *Continue Olanzapine dose 2.5mg, dose can be increased by the GP to 5 mg.*
    2. *Details of therapy for you given.*
    3. *I will refer Roy to CMHT, this will help us understand the progress and whether there could be a role for antidepressants or mood stabilisers.*
    I will be reviewing him again on 01/11/2020"

26. As far as I understand each assessment talked about why Roy was there and what had driven him to do these things, all too late as Roy could not remember much about the incidents.

<u>18 January 2021</u>

27. On 18th January 2021, Roy tried to get out of the car as I was driving, he was saying that he wanted to go back to the water tower to kill himself. I drove him to a police station where he dragged an officer along the road trying to get away from him, he went to the bridge over the dual carriageway and then walked in front of a van deliberately. He was taken to Broomfield Hospital under section 136 by the police as advised by the street triage without any family members. There

was no place available for him at Broomfield Hospital, and so he was transferred to 136 suite at Rochford Hospital.

28. On arrival, Roy was very confused, paranoid and in psychosis. Roy was assessed at Rochford Hospital by Doctor C, Dr [I/S] and social worker [I/S] [I/S] The assessment was aided by ward staff who actually saw Roy in a confused, agitated state as the psychosis had not left him by then. They made the decision for Roy to have a brain scan and urine tests, and so he was transferred to Southend Hospital A&E department for further investigation. I believe the brain scan was normal. He did have a urine infection, and antibiotics were prescribed.

29. Roy was transferred back to Rochford Hospital from Southend Hospital.

30. The following morning, he was placed under section 2 of the Mental health Act and transferred to Southern Hill Hospital in Norfolk as an inpatient.

31. Roy spent 14 days under section at Southern Hill Hospital; he was discharged on the 15th day, the 2nd February 2021. Following his discharge, the community mental health team followed up with a telephone call the next day, but no risk assessment was conducted following the 48-hour contact. A face-to-face appointment should have taken place but did not. No alternative plans were made.

32. Someone did visit my sons house to see Roy on the 4th February 2021, but we were not there so they spoke on the phone. Roy declined any treatment and was discharged from West Essex Home Treatment Team. Roy's GP records note that Roy *"reported feeling well, no thoughts of paranoia or confusion. He was eating and sleeping well. Lynn said that she recognises that the trigger point is when he is not sleeping. She said now she knows that she will be able to prevent another episode. Taking his medication. They recognise that whilst they are waiting to move into the house it is stressful…… 48 hours follow up complete – No further role of WEHTT."* I do not believe that all of this entry is the truth; I stated to the Home Treatment Team that I was able to recognise Roy's triggers, however I do not recall or believe that I said I could prevent another episode. I did not insinuate that Roy should have been discharged from the Home Treatment Team.

33. Roy passed away on 21st February 2021, he was found by the police in the local woods.

34. Following both the incidents in September and December 2020, Roy should have undergone a mental health assessment for an admission for inpatient care and treatment.

Quality, adequacy, process and outcome of the assessments

35. My main comments about the quality, adequacy, process and outcome of the assessments are that the assessments are carried out too late as the doctors only work 9 - 5. Mental health is not governed by time and someone suffering psychosis can appear completely normal again after a few hours. The other comment is no one listened to our family's concerns; myself and my daughter in law had a long telephone conversation with The Derwent Centre, I asked if he would be detained as an inpatient if I did not collect him, and I was told that he would be put out on the street, this is unacceptable.

36. Roy's admission in January 2021 came about due to the incident on 18th January 2021. The mental health unit at Rochford Hospital made the decision to admit Roy under the Mental Health Act 1983 on 19th January 2021. Roy was then transferred to Southern Hill Hospital in Norfolk, where he stayed as an inpatient for 14 days.

37. Roy was very clever at hiding his condition and when I tried to voice my concerns I was not listened to.

38. The admission process is not quick enough; it allows patients like Roy to recover enough to hide their problems at that time.

39. There were occasions when the Street Triage team and emergency services considered for Roy to be admitted, particularly after the incident in December 2020. The police took Roy to a place of safety then the system let him down after he was discharged into the care of the professionals. The response of the professionals was again too late, the doctors did not see Roy until the next morning at 10:30am. Roy was then appearing normal. Relatives were not listened

to; I told Broomfield Hospital and PAH Derwent that what they were seeing was not normal for Roy.

40. In December 2020 when Roy was not admitted, a person was sent to my son's house to see Roy, but he would never admit he had a mental health problem, so it was never going to work by talking to him. There was a couple of phone calls and again he told lies so that he kept his freedom.

41. When Roy was not admitted no other assessments were arranged as I think he was deemed to be coping and did not need any further assessments.

42. Relatives are not listened to, the doctors take the word of a confused, paranoid person rather than Roy's wife or son.

Ward Environment

43. When Roy was under section at Southern Hill Hospital, as a family we did not visit, therefore I am unable to comment on my impression of the ward, environment and suitability. I can only report that Roy said he was cared for, fed and watched. Roy did express that he was not comfortable at all in the ward environment, he would say he could lean over the wall if he wanted to. Roy was uncomfortable with aggressive patients on the ward.

44. Whilst on the ward Roy spent most of his time on his own in his room speaking with his family on the phone. From memory, I think there was a secure area outside where patients could smoke. I am unaware of any activities that were available to him.

45. From my understanding, I believe that Roy's privacy and dignity were respected at all times by the staff. I do not have any concerns about the staff on the ward at Southern Hill Hospital. I did not hear Roy say anything that concerned me about the training or conduct of any staff members.

Care Planning

46. I cannot be certain that Roy was completely involved in his own care plan, but I feel from what Roy said that he was involved in his care. The family on the other

hand, I had to call to find out what was happening regarding Roy's care plan and how he was getting on at the hospital.

47. I do not feel that the family's level of involvement in Roy's care and treatment was adequate nor appropriate. The only time I was involved in the plans for Roy was one telephone call with the doctor and Roy was present. I was told what was happening and that he was to be released even though I did mention I was not certain he was well enough to come home. I should have had the opportunity to speak to the doctors without Roy being present. It was extremely difficult for me to voice my concerns when he was present, after the little I did say he said to me I thought you did not want me to come home, so the impact of one sentence is huge to someone in that condition and environment.

48. My concerns about the formulation and implementation of the care plan is that I understand a 48 hour follow up was to happen, this was a telephone call, they stated we declined a referral to Specialist Mental Health Team Community Mental Health Service, this was not offered. Then on 4th February 2021 someone called home to see Roy, but we were not at and were not told they were coming. They then called at 5pm that day and as Roy told them he was doing well he was discharged from the Home Treatment Team.

49. Roy was referred to Specialist Mental Health Team Community Mental Health Service (SMHTCMHS) and drugs, by Mid Essex Home First Team at home. This referral did not progress as Roy lied on the phone and said he was feeling ok. Roy's drug prescription and diagnosis kept changing, and he became very quiet and extremely depressed. He was not eating or doing anything.

Lack of Diagnosis

50. It seemed no one could make a diagnosis, I accept they tried to get him referred but it's very easy for someone to lie on the phone, much easier if face to face to see how someone reacts. After the 3rd Incident in December 2020, someone came to visit him the next day, I was telling them about what had been happening and Roy was nudging me to stop me, the person actually said '*Roy are you telling Lynne not to say what has been happening*'? So, they were able to see what was going on but on the phone that would be impossible.

51. No one took Roy's problems seriously blaming them on a lack of sleep etc. On one occasion he was not treated as a mental health patient even though I was telling them he was in paranoia, I called him while he was in there and he asked me where he was, he was so confused, he was left on his own in A&E, then discharged as they could not find anything wrong with him, my son found him wandering along the main road.

Medication

52. I do not know if Roy was offered any therapeutic care. Roy did not get any treatment really only drugs. I do not know what treatment he had as an inpatient.

53. His medication for psychosis was stopped by care in the community, the report says that Roy *was not experiencing any psychotic symptoms and did not show any whilst in Southern Hill Hospital*, I told every hospital, department and anyone who was listening that what they were seeing was not his true personality. The doctor I spoke to at Broomfield on 18th December 2020 also agreed saying that Roy was not their 'typical' mental health patient, I also told them that the crisis episodes are getting closer together to which the street triage agreed. Our GP received a letter dated 1st February 2021 from **Doctor D** who is from the crystal centre at Broomfield hospital, which states that Roy's Olanzapine be increased when **Doctor A** at Southern Hill Hospital had stopped it. No one appeared to know what the other was saying or doing.

54. Roy was prescribed Citalopram 20mg daily, and the Olanzapine was stopped as suggested Roy was free from any psychotic symptoms, that very same evening it was clear he was still suffering from psychosis, saying there was someone outside our hotel door and he sat up all night, this was the first night out of hospital and he could not sleep as the medication given to us on release did not include any sleeping tablets.

55. In my opinion the Citalopram was not helping Roy at all so he was released after 14 days if he started taking that medication on the first day as an inpatient that means the full effect of the drug would not been seen for up to 28 days as advised by mental health street triage. These drugs, or lack of the correct ones, sent Roy into a deep depression which led to him taking his own life 19 days after being released, had he been kept in hospital I believe they would have seen the

change and depression in him. On release the medication listed a sleeping tablet, this was the first time I knew about it as in the telephone conversation I was told that long term use of sleeping tablets is not helpful, they did not tell me he had been having a high dose every night whilst an inpatient, these were not included in the medication given on release and Roy's GP was not informed he could be given this. ALL doctors, hospitals etc knew sleep was a big problem for Roy, they failed him by not letting him have some sleep when he returned home. The whole medication issue was a complete farce and let down, no one knew what he was taking etc.

56. Roy is dyslexic, has tinnitus in both ears so does not hear well, suffers with acute anxiety and low self-esteem. I did mention all of this to all the staff Roy came into contact with, however I am not sure it was taken on board. I cannot be sure that they were not considered, but I don't think so. I am unable to give examples as I was not present at any meetings or treatments.

57. I am not aware of Roy being subjected to any abuse, physical or sexual assaults, or being able to harm himself whilst an inpatient. Roy did not raise fears or concerns about his or anyone else's safety on the ward that I am aware of. I did not have any concerns regarding any aspect of Roy's safety whilst he was an inpatient.

58. I believe Roy was placed under a formal observation, I am unsure on the details; Roy said so, and I heard a nurse call out to him very often and he said they looked into the room all the time. I have no concerns about the observations.

59. I was never made aware of any physical restraints Roy may have been subjected to.

60. Roy requested to leave the ward and be discharged, he was denied being discharged on this occasion with my approval; this was two days before his release date. The doctor in charge refused this request, which personally I think this was correct. I have no concerns about Roy's request for leave, the process or outcome. Roy did not have any periods of leave from the ward.

61. I am not aware of any instances where Roy absconded from the ward.

Hospital Transfers

62. Roy was transferred between hospitals several times; Roy was sectioned at Rochford Hospital and transferred to Southern Hill Hospital in Norfolk. Roy was transferred to another ward from the high dependency ward he was first on, Covell Ward, to another lower security ward.

63. Whilst at Rochford, Roy was taken to Southend General Hospital for a CT scan of the head and bloods were taken.

64. Broomfield Hospital transferred Roy to The Derwent Centre, in Harlow on 18th December 2020. Broomfield Hospital also transferred Roy to Rochford Hospital on 18th January 2021. A visit was made to Southend Hospital A&E on 18th January 2021. The transfer to Southern Hill Hospital was on the 19th January 2021. Roy was transferred to Southern Hill Hospital as there were no beds in Essex. I cannot remember the date he changed wards at Southern Hill Hospital.

65. My only concern is that Broomfield Hospital could not place Roy there and access him. I would have liked Roy to have stayed at Rochford after sectioning but again no beds were available, it was very stressful to keep being moved, for Roy and myself, especially when Roy did not understand what was happening

66. I received a phone call on 18th December 2020 to tell me Roy was being taken to the Derwent Centre. I had to call Broomfield to find out what was happening.

67. Rochford kept me informed by telephone about what was happening whilst Roy was there. I had to call Southern Hill Hospital to tell them what had been happening when Roy was being transferred. From memory I think I may have received one phone call from them but otherwise I had to call them.

68. With all the transfers none of the departments could access Roy's medical records and so they relied on the police, street triage and myself to give them the information they needed. Not all members of staff actually listened and took what Roy was telling them to be correct as he appeared to be in control even though I told all of them what they were seeing was not his true personality, but no one listened, for example when I asked the consultant at Southern Hill if Roy had actually had a brain scan, he asked Roy, who confirmed he had and it was clear.

Southern Hill Hospital should have had that information and no relied on the patient.

Discharge

69. Roy was discharged on 2nd February 2021 from Southern Hill Hospital. I am not sure I ever had a firm decision as to why Roy was being discharged. I believe it was because Roy appeared to be getting on ok but had only had his new medication for 2 weeks.

70. Roy was present at the meeting to discuss his discharge. However, I don't think Roy had any involvement in planning his discharge or any follow up care, as he was not mentally capable to retain that information and make decisions at that time.

71. I asked if Roy was well enough to be discharge, and I was assured that he was. I was told what next steps would happen; however, I did not have any say in this or his discharge plans. From memory, I think we were given four days' notice prior to Roy's discharge. I was told a discharge plan would be in place, but I did not know what it entailed at the time. No information about the discharge plan/arrangements were shared with me upon Roy's discharge, I was only told that the Crisis team would be contacted.

72. Roy had only taken his new medication for 2 weeks on his release; this is not long enough to see if it would help. The street triage team confirmed to me on one occasion that it took four weeks to truly see if it would work, that is why on 18 January 2021, she queried the episodes being so close together, i.e. 18th December 2020 and then 18th January 2021, she suggested that the medication he was being given then was not going to help him. It felt as though in the telephone meeting that I was putting pressure on the team to release Roy early as he was so far away from home etc, that is untrue as I could not visit. It made no difference to me where he was, I would still travel, this was not included in any paperwork they sent.

73. Roy had a telephone call on two occasions, of course he lied how he was feeling as he did not want to go back to hospital. Roy did not want anyone coming to

where we were living, a face to face would have been better as I could have taken him there and then visually, they would see he was stressed and unwell.

Family Involvement

74. All the support Roy received was by telephone, this is not acceptable to a person who is suffering from paranoia, they need to be seen in person. I asked for help on at least two occasions as I felt unable to cope with working and looking after Roy 24/7, but I never received any calls or any advice at all. It was virtually non-existent, when they did visit on one occasion, I was not told they were coming, so the next time they tried we missed them, but they never returned just called and asked how he was

75. As I was never allowed to be present when Roy was being assessed it is difficult to comment on Roy's involvement about decisions relating to his care; he could well have been told about decisions but he would not have retained that information and would not been able to relay it to me as he had very little memory of the episodes.

76. The level of involvement was not appropriate, a responsible adult should have been present and told about the decisions that were going to happen. When I did call and I was told he was being released it was all signed and sealed, there was no communication apart from Southern Hill Hospital but that was not appropriate as Roy was listening and even the comment I did make about him being well enough to come home set off a high level of anxiety as he thought I was saying I did not want him to come home. The doctors seem to forget that they were not talking to a rational in the present person but instead a mentally ill one.

77. I was not involved much at all in Roy's care and treatment, I was asked about Roy's physical health and what had been happening, but I do not believe these conversations had anything to do with any decision they made.

78. I do not believe I had any input at all apart from Rochford as a social worker took a long time to ask me what had been happening

79. I don't not feel that I was listened to. The only time at Southern Hill Hospital that I was listened to was when I spoke to the ward sister on Roy's arrival, the

consultant never questioned or asked me about Roy, I firmly believe that a lot of this information was not passed onto the consultant as I told the sister Roy had a splenic artery aneurysm but in the paper work the consultant states Roy had a aneurysm in his left arm, as that is what Roy told him when he was confused. This is just one instance of the doctors believing what patients are telling them, in Roy's case he was confused and would say the best thing he could to be released. He told me he played cards etc whilst in Southern Hill Hospital as he would be released earlier as he was seen to be doing 'normal' things.

80. No in-depth information was given to me, I was just told about his release really – The Derwent Centre told me that they would put Roy out on the street if I did not go to collect him and that if he had cut his wrists any deeper, he would of died, that was a disgraceful thing to say.

81. I have a lot of concerns about the extent to which my family and I were involved in Roy's care. It did not happen at all.

82. I was able to contact Roy when he was an inpatient at Southern Hill Hospital, but I was not able to visit. I was not provided any information from staff members. I needed more information about caring for Roy, not just told to run him a hot bath and read a book, this proves that they did not understand the severity of Roy's illness and because they did not listen to me it was missed.

Complaints History

83. We were given no information about how to raise concerns about Roy's safety. I raised a complaint to the Derwent Centre on 19th December 2020. I complained as I wanted Roy to be detained as his episode on 18th December 2020 was very major and as a family, we were all concerned for his safety. I also raised the question 'why Roy was asked if he would be an informal patent on the ward' which he refuses saying he wanted to get on with his life, so if a patient says they are fine that's it they are?? The paperwork later states that Roy in not suffering from a mental of nature/degree which warrants hospital admission, so why ask if he would stay as an informal patient. I was told Roy was fine to go home and if I did not arrange from him to be collected, he would be discharged on the street.

84. The response received was not adequate or appropriate, no action was taken. Rubbish handling.

85. I raised concerns with all of Roy's doctors that I was not being listened to. These concerns were raised after every mental health episode by telephone. None of these calls were successful, and no action was taken.

Aftermath of Roy's Death

86. Roy was released from Southern Hill Hospital on 2nd February 2021, he died on 21st February 2021. I found out that Roy had died as I called the police to say he was missing, and I had found his car. They took over with tracker dogs whilst a police officer stayed with me and my daughter in law, it was this officer who told me they had found a body, I then went to the scene and identified Roy in the ambulance.

87. I was told that the coroner's office would be advised, and Roy would be taken to the mortuary at Broomfield Hospital by ambulance.

88. A few days after Roy's passing, support was provided by the police and Coroner's office. I have no concerns from the Police and the Coroner's office.

89. We were not legally represented for Roy's inquest. We found the coroner's office very helpful and respectful. I did not have any concerns regarding the inquest, only that I feel that the coroner should have pressed the doctor from Southern Hill Hospital as to why Roy was released after only 15 days of medication and why they did not wait to see if that medication would have been helpful. It is my opinion that this contributed to Roy's deterioration and death as he sank into a deep depression after release from hospital as the medication was not working.

90. Following Roy's passing, I received a phone call from the mental health office at Broomfield Hospital as the street triage nurse who attended on two occasions asked for her condolences to be passed to myself and family. I felt that this officer could have offered more but I was in no good place to really question this at the time.

91. I received a letter from Southern Hill Hospital offering their condolences, which also included Roy's sectioning papers with reasons to his detention. I asked Southern Hill Hospital for sight of the handover notes from Rochford Hospital, however I was told that patient notes between organisations cannot be shared due to GDPR regulations.

Internal Investigation

92. I also received a letter from [I/S], head of patient safety incident management & mortality dated 11th March 2021 advising that there was to be an internal investigation into Roy's death. I was offered the chance to ask questions and share my views on Roy's care and given contact details of a Family Liaison Officer (FLO). I was told to contact my FLO. The investigations were undertaken on 9 April 2021, I cannot recall how long they lasted. I had to ask for updates as we were not involved until I sent in questions following the completion of the report.

93. I have a copy of the report, and I do not agree with all of the findings. There are various mistakes about dates, facts and what was said. The report looked like it was hurriedly put together, facts and dates being incorrect. I was not liaised with about this until I got the report which I then had to make notes and corrections to. At no time on leaving Southern Hill Hospital did someone explain to us that Roy would be given further treatment at home on an outpatient's basis. I would have actively been supporting this and encouraging Roy to engage with, which he would have done, as it probably would be by telephone. We agreed to counselling but we were never contacted or offered any advice. I asked for help for myself to cope and I was told I would be contacted but again nothing happened.

94. I was not told about the process of any external investigations into Roy's death.

95. I asked the CQC to look into the medication mix up at Southern Hill Hospital, I believe they did and was going to go back to investigate but I did not hear the final outcome. I received a document from EPUT which is named as Patient Safety Incident Investigation Report. This report stated that IAPT refused Roy's referral. In the same report it states that there was not a record of the MDT meeting, when I questioned this I was told: ***There is evidence that his care was***

discussed in the Home Treatment Team handover meeting which is recorded in the teams handover sheet. However the investigation recognised that an MDT discussion did not take place for Mr B within the Home Treatment Team because he was not formally under their service as an alternative to hospital admission but as an intervention to offer a 48 hour foll after discharge. The 48 hours follow up was a phone call. I also asked why there was no comment from Southern Hill Hospital on anything, I was told that EPUT's investigation were compiled by gathering information from the clinical records and staff. Southern Hill Hospital is not commissioned by EPUT and therefore information from this hospital had not been included in the report. There is a list of immiediate actions to be taken, if required.

96. I had involvement with the CQC's investigations, I had to contact the FLO with any questions we had.

97. There was not any support from the Trust, not that I feel was adequate. If Southern Hill Hospital is not part of EPUT, then why transfer Roy there. If it is a private hospital, then why do they have an NHS email address. EPUT say they used clinical notes to compile the report then why is it that none of the hospitals involved could access Roy's notes to confirm what had been happening. The report had 'Lessons Learnt' section which were:

    1. An updated risk assessment could not be located on the record system following the 48-hour contact.
    2. A face to face 48 hours intervention should have been completed that could have been completed by video.
    3. To ensure that all clinicians are able to access HIE, where a person's clinical care is documented over a number of electronic systems.

EPUT spent a lot of time saying that we declined any help etc. Had this so-called help been explained to me exactly what it was then I may have been able to persuade Roy to attend for help, the only help that we were offered was a conversation on the telephone, Roy managed to convince whoever it was that he was fine and did not need help had he been seen in person they would of seen his anxious state, leg tapping, hands shaking, sweating. No effort was made to give any help to us in any form.

Failing in Roy's Treatment

98. Rochford Hospital were the only team that assessed Roy when he was having one of his episodes, therefore resulting in the section being put in place, staff there were extremely helpful to me and the social worker. They listened to what I was telling them and used my information with what they could see going on to make the decision. The mental health street triage nurse was another very helpful person, she witnessed some difficult situations. She recommended Roy be detained with a view to be sectioned however I do not believe that she was listened to either. The police tried to get us help and the ambulance service to, but it was not help, all the services were very very helpful and got Roy to a place of safety. The only team that let us down was the mental health teams in various units.

99. Roy would never complain about his treatment, his main focus was getting released from section and coming home. Therefore, I assume his treatment was of a good nature.

100. The street triage nurse was appalled that her request for follow up treatment had not been carried out. She requested in December 2020 that Roy have blood tests and a brain scan, when I next saw her 4 weeks later the first thing she asked me was what did the scan show, I was not told he should have a scan. She requested this at Broomfield and then I assume this should have been passed to The Derwent Centre, in Harlow. The scan was carried out from A&E Rochford Hospital in Southend.

101. The failings in Roy's treatment were that none of the doctors listened to what I had to tell them about his behaviour apart from Rochford. As Roy 'appeared' to be acting normal to them they took what he was saying to be the truth, for instance when asked if he wanted to end his life when he climbed the tower in December 2020 he replied no. However, when I questioned him after collecting him from the hospital, he said he went up the tower to jump but a lot of 'film crew' turned up, these were the emergency services which over 50 personnel were involved from all aspects including negotiators.

102. At Southern Hill Hospital and The Derwent Centre, he told them he had an aneurysm in his left arm, it was actually in his splenic artery, and he wore a

medical identification bracelet, so they did not look at that at all. The episodes that Roy had were serious, but NO ONE LISTENED TO ME. They preferred to believe a paranoid, psychotic person, saying that as he had been awake for 72 hours, that explains his behaviour. He had not been awake for 72 hours that was just what he imagined but no one asked me to confirm these things. They said that I had told them Roy's father and uncle had died [I/S] which is true, and that was what was troubling Roy. That was rubbish, and I did not tell them that they got that from Roy's history.

103. Southern Hill Hospital stopped his psychotic medication and told him to have a hot bath and read a book, they have obviously never seen a person in this state of distress, even if I had got him in the bath, he would probably tried to drown himself in that state. So to sum it up Roy never really got any treatment, all Southern Hill Hospital did was give him sleeping tablets every night and said that he was fine after a good night's sleep. We were not given any sleeping tablets on discharge so the first night in the hotel the paranoia crept back in, and we did not sleep at all, it went downhill for the next 2 weeks until Roy passed away.

104. I am disgusted and disappointed with the so-called treatment I pushed for Roy to be sectioned but in fact with hindsight that was the wrong thing to do as they did not help.

105. Instead of taking what he said as true, speaking to myself was the better option for all teams. Roy should have been kept in Sothern Hill Hospital for at least another 2 weeks to see if the medication they had given him and the one they had stopped were actually good for him and working, proven in the end they were not as he was in a deep depression when he passed away.

Recommendations

106. I found every time Roy was taken to a place of safety he could not be assessed by a physiatrist until the hours of 9am – 5pm, by this time Roy was out of the paranoia and so they never saw him in this state, only the ward sister at Rochford actually recorded and saw his mental condition. This was included in his assessment as by this time the next day Roy was appearing to be of normal mental state. These physiatrists should be available 24 hours a day. I think this is an issue that should be raised.

107. The mental health teams could try communication. Speak with the family, not just the patient. More explanations as to what is happening and what medication is being given on discharge and what the next steps were to be.

108. For me, giving someone a sleeping tablet every night is just a way of keeping patients quiet, that is not a treatment or an insight as to why patients do the things they do, and how the so-called professionals could help to get patients back on track. I realise the doctors are not miracle workers and the patients have to want to have help but to not listen or understand how a patient feels is unacceptable when patients like Roy do not understand why they do the things they do themselves.

109. On discharge patients and relatives should be given details of who and when they will be contacted when back in the community. There needs to be clear communication between different health authorities, we signed a letter years ago to say that our medical records may be shared, at no time was Roy's history shared, there was hardly any communication.

110. The patient's family, relatives, friends need to be listened to not treated like you are a nuisance. The system needs to recognise when a patient is not telling the truth, do not believe every word they are saying, in Roy's case a lot of what he said was incorrect so the doctors did not get a correct insight into his problems. Roy stood no chance of recovery, the doctors did not realise the seriousness of Roy's actions and I do not believe that Harlow and Southern Hill Hospital never saw the reports from the street triage, this person sat for five hours watching Roy up the water tower she had the most input into his mental condition. I do not feel that her comments and valuation of Roy were taken seriously. This is very disappointing to our family, I fought for Roy to be sectioned believing that he would treat and go on the live his life, not leave hospital in a paranoid state which the doctors failed to see, they helped him to take his own life.

111. My recommendations are:

- Assessments:

- As a family our concerns are the way assessments are carried out. These assessments need to be carried out as soon as possible after the patient has been put in police care and taken to a place of safety. Every time Roy was arrested by the police he was not seen for assessment until the next day, when I questioned this, I was told the doctors only are available 9-5 and not at weekends. This was unacceptable for Roy as he was coming out of his paranoia and crisis by then and appeared 'normal' to the doctors so talked his way out as the doctors did not discuss with me what had been happening they took Roy's word that he was ok when I kept trying to tell them what they were seeing was not Roy in a normal mental state.
- In A&E at Broomfield in December 2020 the doctor I did actually get to speak to told me himself that Roy was not their 'typical' mental health patient but they still just sent him off the Harlow to be assessed the following morning about 10.30am.
- In my opinion when these assessments are going to take place the family should be spoke to first to understand what had been happening, not get a phone call after it has taken place to say come pick him up or he will be put out on the street. Had they actually done that Roy would not of known where he was or what to do so I had to get very annoyed with them and insist they did not release Roy until I got there, which they did.
- Roy was only sectioned due to the fact that when he arrived at Rochford hospital in January 2021 he was in crisis, so the sister and social worker actually did see how he was behaving and passed this onto the assessment doctors the next morning, from that he was placed under section.
- Roy was then taken to Southern Hill Hospital in Norfolk, only time I got to speak to the doctors was when they called me to have a conversation with me, at their end the doctors and other people was present but so was Roy, how could I express exactly what I thought with Roy sitting there listening. That phone call was not to discuss his illness but to tell me what they had diagnosed and that he could be taken off section.

- Drugs:
  - At Southern Hill Hospital they confirmed that some of Roy's problems was due to lack of sleep so gave him sleeping tablets every night but did not give him any to take home so first night there was a problem straight

away. Any new drugs should be monitored for at least 28 days to make sure they are going to work; they did not do that at Southern Hill Hospital and

  - I am convinced that was the reason Roy fell into a deep depression and took his own life.
  - Any of the doctors I come across did not seem to be able to see through Roy telling them fibs to try to get released so had they spoke with me at the same time I could of told them he was lying.

- The whole assessment procedure is not fit for purpose.
- There needs to be more back up from the professionals after leaving hospital we were not told someone would visit, they just turned up. I was supposed to be offered some assistance in dealing with Roy as I was exhausted but I never heard a thing.
- Long and short of my opinions are they did not listen to me and there was a complete lack of communication.

Statement of Truth

I believe the content of this statement to be true.

SIGNED [I/S] ……..

MS LYNNE BREAKER-ROLFE

DATED 13 November 2025……...

WITNESS STATEMENT OF LYNNE BREAKER-ROLFE PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

APPENDIX 1 – LIST OF DICUMENTS WHICH I HAVE

i. Medical Records, Record Entries, Summaries, Assessments and Reports

Document	Date
GP records.	Undated
Medical record entry of incident 18.12.2020	18.12.2020
Report of Mental Health Assessment, Princess Alexandra Hospital Harlow.	18.12.2020
Medical record entry from Crisis Intervention.	19.12.2020
EPUT HTT Gatekeeping Discussions document.	19.12.2020
EPUT Initial Assessment of Needs and Risk.	20.12.2020
NEPT Case Note History, 01.01.2017 – 07.04.2021.	23.12.2020
Case Note History from Nurse A Street Triage Team.	18.01.2021
Essex Police Section 1 Detention Monitoring and Joint Risk Assessment Handover Form.	18.01.2021
Interim AMHP Report for Hospital Admission.	19.01.2021
Continuation/Progress Outcome Sheet from Rochford Hospital suite 136 , including radiology examination of head.	19.01.2021
Report of Mental Health Assessment, Rochford Hospital - Incomplete set.	19.01.2021
List of Roy's medication January 2021.	Undated
Continuation / Progress Outcome Sheet	02.02.2021
Continuation / Progress Outcome Sheet	04.02.2021
Datix Report.	21.02.2021
Patient Safety Incident Investigation Report.	09.04.2021
Patient Safety Incident Investigation Addendum Report.	13.07.2021
Doctor A's note of telephone call with Roy and Lynne.	Undated
List of Roy's medication at discharge.	Undated
GP patient summary	Undated.

ii. Witness Statements

Document	Date
Statement of Nurse A Street Triage Team.	17.12.2020
Statement of Doctor A	11.06.2021

iii. Inquest

Document	Date
Record of Inquest.	Undated
Letter from Coroner to Lynne.	26.07.2021

iv. Correspondence

Document	Date
Internal email from EPUT to MIDAAS.	21.12.2020
Letter from Dr D to GP (GP), enclosing care plan.	01.02.2021
Internal EPUT email	03.02.2021
Letter from EPUT to GP, enclosing 48 hour follow up.	04.02.2021

Letter from [I/S] Head of Patient Safety Incident Management & Mortality to Lynne.	11.03.2021

v.

Document	Date
Lynne's letter to HM Senior Coroner Mr Lincoln Brookes	22.04.2021
Letter from HM Coroner's Officer to Lynne	27.07.2021
Lynne's amendments to Patient Safety Investigation Report.	Undated.
Lynne's notes of the two weeks that Roy spent at home after discharge from Southern Hill Hospital.	Undated.
Lynne's comments / questions to EPUT, Southern Hill Hospital and the NHS.	Undated.