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

1. I, **VICTORIA SEBASTIAN** **[I/S]**, **[I/S]**, am the mother of the late Elise Sebastian (born on 24/05/2004 and died on 19/04/2021) **WILL SAY AS FOLLOWS**: -

2. I am making this statement based on my memory of events, from my understanding of my late daughter's records / other disclosure and the evidence placed before the inquest (into my daughter's death).

Diagnosis

3. I have set out below, in chronological order, as clearly as I am able, Elise's physical and mental health history, including the diagnoses she received over time and the daily realities she faced from a very young age. This is not just a record of symptoms and events, but an account of the challenges that shaped Elise's life, her struggles, her courage, and, ultimately, the failings in her care.

4. Elise was the youngest of my four children and was just 16 years old at the time of her death. Even as a young child, Elise was different from my other children – socially anxious, often overwhelmed and sensitive to the world around her. Her anxiety could become so intense that she would sometimes vomit.

5. From early childhood, Elise suffered from ongoing bowel problems, which looking back, I believe became one of the main sources of her anxiety as she grew older. She frequently experienced severe abdominal pain and episodes of rectal bleeding, which were extremely distressing and frightening for her. These symptoms affected her daily life and caused her a great deal of worry and embarrassment. Just prior to Elise's death, she was finally diagnosed with an internal rectal prolapse and was on the waiting list for proposed treatment.

6. In addition, Elise had kyphoscoliosis (complex spinal deformity), and had to spend around two years wearing a back brace, which was not only bulky and uncomfortable but also obvious visually. Having to wear it to school daily was very challenging for her, and many of her peers were very unkind about it. The discomfort and the often-unpleasant teasing by her schoolmates really impacted her confidence.

7. The combination of her serious physical health problems and the bullying she experienced at school wore her down, both emotionally and mentally. By the age of 10 or 11, Elise began to self-harm by cutting her arms. It was devastating as her mother to watch her struggle.

8. In 2016, when Elise was just 12 years old, she was referred to the community Child Mental Health Services. The records state that she was struggling with "*school anxiety*". However, Elise was battling far more than that; she was struggling to cope with all the numerous challenges being thrown at her. As her family, we supported her as best we could, but we felt out of our depth and placed our trust in 'professionals' to guide us. Looking back, I don't think

any of those responsible for Elise's care truly understood the extent of her suffering, or how close to crisis she often was, even when she had good days.

9. When she was just 13 years old, Elise then had to undergo major spinal surgery. Matters were further complicated by the fact that Elise began experiencing myoclonic seizures. She was prescribed medication to help manage these episodes, and by and large, the seizures were well controlled, but it was yet another thing for Elise to cope with at such a very young age.

10. Concerns were also raised about the possibility that Elise had Ehlers-Danlos Syndrome, a genetic connective tissue disorder. She was referred to the Rheumatology Department at Colchester Hospital for further investigation; however, the waiting list was 3-4 months long. A referral letter dated March 2021 detailed the wide range of symptoms Elise was experiencing, such as a "*bowel prolapse, popping joints, dislocation of her small joints in her toes and hands, easy bruising and stretch marks."* Tragically, the referral was not progressed in time, and the rheumatology clinic contacted me on the day Elise died. I cannot express how distressing this was. Elise was living in constant physical pain and discomfort, and I felt that no one truly listened to how much she was struggling until it was too late.

11. Despite struggling with anxiety and depression, Elise never lost sight of her hopes for the future. She was determined to finish school and complete an apprenticeship at Colchester Zoo. It was Elise's dream to become a veterinary nurse, a career that reflected her compassionate and caring nature.

12. It was not until March 2020, when Elise was aged 16, that she was finally diagnosed with high-functioning autism spectrum disorder (ASD) by community paediatricians. This diagnosis helped to explain a lot about Elise, her difficulties with social interaction, her struggles to communicate her feelings, and her tendency to become overwhelmed. But by then, Elise had already spent years without the understanding or tailored support that an earlier diagnosis might have brought.

Admissions

13. By the time Elise was 15, she had already had four informal admissions to adolescent mental health units. For the purpose of this statement, I will focus mainly on her final admission. However, I will briefly discuss her previous admissions and the events leading to Elise's final admission to the St Aubyn's Centre.

September 2019- January 2021

Rochford Hospital

14. By late 2019, Elise's mental health had deteriorated significantly, and she was self-harming almost daily. On 30th August 2019, Elise took an overdose of paracetamol tablets, her third overdose that month. At that time, her father and I did not lock our car doors, as we lived in a quiet, rural area and had never felt it was necessary. However, on that day, Elise accessed my car and took the paracetamol I kept there. When she later confessed to me what she had done, I rushed her straight to Broomfield Hospital, where she underwent blood tests and close monitoring for about eight hours.

15. Following concerns after Elise's overdose, she was referred by her local Emotional Wellbeing and Mental Health Service (EWMHS) to the Poplar Adolescent Unit at Rochford Hospital. Around this time, Elise had also just learned that a peer at her school died by suicide, which was a significant trigger for her own deterioration.

16. At the Poplar Adolescent Unit, she was reviewed by Dr A a consultant psychiatrist, who recommended that she be admitted as an inpatient for her safety and treatment.

17. The records state that Elise presented with *"significant emotional dysregulation, anxiety, low mood and persistent thoughts of 10/10 intensity"*.

18. On 4th September 2019, Elise was admitted informally (initially) to the Poplar Adolescent Unit, where she stayed until 26th November. This was the beginning of a series of hospital admissions that would sadly come to define much of her teenage years.

19. On 21st September, it was decided to convert Elise's inpatient status and, from that point on, she was detained under Section 2 of the Mental Health Act. Being separated from her family was extremely difficult for Elise, and being around other distressed young people only increased her anxiety.

20. Although Elise was granted s.17 leave at times, these experiences were mixed. Sometimes she coped well and would enjoy her leave, while on other occasions, she self-harmed or even attempted to overdose. I was also very

concerned that Elise was able to bring dangerous items, such as a piece of glass and a sharp blade, back onto the ward and use them to harm herself.

21. Despite these challenges, Elise made some noticeable progress during this admission. According to a psychological report from Dr B dated 19th December 2019, Elise attended the individual psychological assessments offered to her while on the unit. Dr B also noted that Elise engaged with the sessions, despite finding it difficult to discuss her feelings, and she participated in the group programme.

22. As a family, we felt that she appeared more settled and engaged with those around her. We felt that she was beginning to return to her old self.

The Priory Roehampton

23. On 20th December 2019, Elise was admitted to the Priory Roehampton, initially as an informal patient and later detained under Section 3 of the Mental Health Act.

24. We believed Elise had been discharged from her previous admission too early. Although she initially seemed to be doing well at home, her self-harming behaviour escalated to the point that we had to remove all potential ligature points in our house, such as light fittings, remove the lock on the bathroom door, and remove cleaning products, as Elise had been ingesting them. At times, Elise was self-harming twice a day, which was terrifying for us.

25. Elise stayed at the Priory until her discharge on 19th April 2020. I do not have access to Elise's medical records from this admission; however, I recollect that she described this stay as largely positive, and we felt she benefited from the structure and support provided. It is also my understanding that during this admission, Elise was also finally diagnosed with Autism.

The Priory Chelmsford

26. Elise's third admission took place at the Priory Chelmsford, where she was admitted informally on 4th June 2020, and discharged on 25th June.

27. I also do not have access to the medical records from this admission; however, I recollect that the aim of this admission was to try to break Elise's cycle of self-harming, as the incidents and suicide attempts had increased since her previous discharge.

28. Unfortunately, I remember that Elise was bullied by other patients on the ward, and this caused her a great deal of stress. I heard other kids threatening her. Elise told me that the atmosphere was not helpful and that some of the other young people even encouraged each other to self-harm. I was very concerned about the impact this was having on her, and in the end, I took her home as it was clearly not a supportive environment. It felt more like a detention centre. I do not feel that this admission gave her a real chance to stabilise or recover – in fact it was quite the opposite, it caused her a lot of harm.

The St Aubyn Centre

29. Elise's fourth admission was to Longview Ward at the St Aubyn Centre, from 11th September 2020 to 7th January 2021. Initially, a bed was offered to Elise in Sheffield, but we were very concerned about her being so far from home. Eventually, a bed became available at the St Aubyn's Centre.

30. In the three months prior to her discharge, Elise had made several attempts on her life. At first, we anticipated that this would be a relatively short admission, and I hoped that this placement would finally lead to the meaningful and lasting improvement in Elise's mental health that she so desperately needed. Unfortunately, that was not the case.

31. During her admission, Elise's mental state significantly deteriorated, and she was self-harming and attempting to ligature nearly every day. Elise was initially admitted informally; however, following a serious ligature incident, she was detained under Section 3 on 18th October. During the Mental Health Act assessment, Elise reported that, so far, she could not identify anything that had helped her cope.

32. We began to notice changes in Elise's behaviour which were out of character for her. She could be irritable, and at times, came across as hostile towards staff and other patients. On the 25th September, there was a serious incident involving another patient that resulted in Elise being physically assaulted. As her parents, we were shocked that she was not kept safe in what was meant to be a secure environment. The police were called – I cannot now recall what the outcome of this was, or if any meaningful action was taken.

33. The discharge summary dated 7th January 2021 noted that: -

"On the ward, Elise's mood tended to fluctuate fairly rapidly and often to extremes. When bright in mood, she would be pleasant and able to engage with peers and staff, with some good attendance at therapeutic groups and Education. However, when experiencing periods of lower mood, her engagement would reduce rapidly, alongside a significant increase in her risk profile. At such times, Elise would become hostile towards staff, and kicking through doors."

Whilst I do not dispute that her behaviour could be more challenging at times, I believe this needs to be understood in context.

34. Following an incident on 15th September, a Datix report records that Elise told staff, *"you do not care about anyone else"* and *"you just laugh at me"*. The records also show that Elise had asked to be transferred to the Priory Roehampton or Chelmsford, as she disliked the environment at the St Aubyn Centre and preferred the staff there. In my view, Elise's behaviour on the ward was not due to her being a difficult or aggressive child. Rather, I believe her distress escalated because she did not feel cared for or understood.

35. I also understand from the records that Elise began to report experiencing psychotic-like symptoms, including hearing voices telling her to kill herself. Elise said that she *"feels people are following her, observing her", and "taking pictures of her"*. Given everything that had already been reported, her increased distress, her feelings of not being cared for, and her difficulties managing her emotions, I would have expected these reports to be treated with urgency. However, I do not know whether these symptoms were properly investigated or whether an assessment took place.

36. Around the same time, the records describe Elise as experiencing *"significant health anxiety."* On 12th September 2020, Elise reported abdominal pain and blood in her stool. From what I can see, the plan was simply to continue monitoring her, with no specific treatment put in place. The notes describe her as being *"highly preoccupied"* with her symptoms and would need almost *"constant reassurance"* from the medical and nursing team. From my perspective, this was another example of Elise's concerns not being fully taken seriously. Elise had several diagnosed physical health conditions, and I worry that her autism and mental health difficulties meant that her physical symptoms were too easily attributed to anxiety, rather than properly investigated.

January – March 2021

37. Following her discharge from Longview on 7th January 2021, I initially thought Elise was making very good progress. At home, she was energetic and had not had any self-harm incidents for a few weeks. I even began thinking about replacing the curtains I had taken down during a previous period when her self-harming had been bad.

38. As part of her community support plan, she had help from her care coordinator, C, and received both individual and family therapy from her therapist, [I/S]. As a family, we tried to engage with the therapy, but due to the circumstances at the time, it was of limited benefit and did not fully meet Elise's needs.

39. In February 2021, concerns about Elise's ongoing bowel problems led us to seek a private consultation with Dr D, a consultant surgeon at Ramsay

Springfield Hospital. Following that appointment, she was referred to Dr [E], a gastroenterologist at Broomfield Hospital, who performed a sigmoidoscopy. Elise was subsequently diagnosed with an internal rectal prolapse, but we were told there was a six-month wait for the proposed treatment. I believe this was a significant source of her anxiety and one of the reasons for the subsequent deterioration in her mental health. The condition caused her stomach aches, bleeding, and left her feeling very drained, and the thought of waiting so long for treatment was so overwhelming for her.

40. Elise had a very bubbly and caring personality, but her mood could change dramatically. On her bad days, she was extremely low, often with no clear trigger, and the severity of her self-harm varied. Sometimes, when she told me she had ingested bleach or cleaning products, we would take her to A&E and the amounts found were minimal. However, there were other times when she self-harmed, such as by cutting, which could easily have put her life at risk. While I loved having her at home, it was also very stressful, and I was constantly on edge, worried that something awful might happen.

41. On March 2nd, 2021, my worst fears came true. While out for a walk with her support worker, Elise jumped from a bridge into a river [I/S]. The police and paramedics were called, and she was rescued from the river with thankfully only minimal injuries. Elise was taken to the hospital but was discharged the same day. My understanding is that she was spoken to by psychiatrists who decided she was well enough to go home.

42. Following her discharge, Elise had experienced only three incidents of self-harm, and I honestly thought she was doing better. Her attempt to end her life seemed so impulsive, and there had been no warning signs.

The St Aubyn Centre

43. Following Elise's suicide attempt, on 4th March 2021, Elise's care coordinator came to our house and, seeing how unwell she was, made the decision to get Elise readmitted to Longview Ward at the St Aubyn Centre under Section 2 of the Mental Health Act.

44. Upon admission, an initial assessment was completed. Two main triggers for her distress were identified. The first was Elise's concerns about my relationship with her father; we were going through a difficult time, and Elise found change very challenging. The second trigger was her anxiety regarding her physical health, particularly her bowel problems, and the fear of waiting so long for the surgery she desperately needed.

45. I also understand from the records that a care plan was put in place, and due to Elise's repeated history of self-harming, she was placed on 'level 2' observations.

46. I remember discussing the plan for her admission with Dr F, the psychiatrist. We agreed to aim for a short admission to stabilise Elise's risks and discharge her back to the community plan. An email from G dated 26th March 2021 to H sets out the plan for Elise's admission: -

"Elise has already demonstrated that she is now more able to regulate her emotions and has shown much improvement since her admission. Time in hospital can often add to Elise's distress and comfort and the environment can be very difficult for her. It is noted that Elise has had many admissions.

There is a pattern of crisis management when she becomes overwhelmed in the community. However, the majority of time spent in the community she has managed well and seems to be moving forward in her life and is very future focussed. She is also engaging very well with her community support team, which is a notable achievement for her. Considering this, it is important to support Elise with her wish to return home and to do this in a safe and gradual way."

47. If this failed, it was agreed that a referral to a low secure unit would need to be considered.

48. Upon admission, Elise was unwell and experiencing sickness and diarrhoea. She was treated for a Clostridioides difficile infection and had to be nursed in isolation until her symptoms subsided on the 16th March.

49. Once Elise had started to feel better, I understand that she initially declined to take part in the therapy sessions. Despite this, the records show Elise did engage well with the other patients and staff, attended education sessions, and began learning to play the guitar. We felt that Elise was coping well, and she was desperate to be granted home leave. It was eventually agreed that Elise could have up to 8 hours of home leave, up to three times a week.

50. I understand that the plan was that if Elise continued to manage in the community, she may have been able to become an informal patient when her section expired on 6th April 2021.

51. In terms of medication, I understand from the records that Elise was being prescribed:

- Topiramate 75mg BD
- Aripiprazole 5mg BD
- Sertraline 200mg
- Lamotrigine 75mg
- Vitamin D OD
- Ferrous Sulphate 200mg OD
- Rigevidon
- Promethazine 20mg
- PRN Paracetamol 500mg
- PRN Diorlyte sachets PRN

52. I thought that the Sertraline and Aripiprazole had been helping Elise, and I was reluctant for her medication to be changed. However, Elise told me that she was experiencing depersonalization and feeling emotionally numb. I understand these could have been side effects of the medication, and as a result, she asked for her treatment to be changed.

53. In a statement dated prepared for the Inquest, Dr F stated that Elise:

"[Re medication] … expressed feeling that it was not helpful. We agreed to trial reducing the dose slowly and gradually to consider switching to an alternative antidepressant [citalopram]".

54. Accordingly, On 24th March Dr F reduced the dose of sertraline to 175mg from 200mg.

55. However, shortly afterwards, Elise asked for the dose to be increased back to 200mg and on 29th March, and during an MDT review, she was prescribed 200mg.

56. Dr F admits in her witness statement (referred to above) that this increase did not in fact happen.

57. What had actually happened was that on 29th March, the 175mg dose had been crossed out with the intention of rewriting the 200mg dose. However, as there was no space on the chart for the updated prescription, Dr F asked a junior doctor to rewrite it once a new drug chart became available.

58. Later, on the 6th April, Elise's Section 2 was rescinded, and she agreed to stay as an informal patient. Elise was then given home leave until the 9th April. It was only then that I noticed Elise had not been given her medication. I immediately contacted the ward to find out what had happened, and I was told, incorrectly, that Elise's medication had been stopped. I later found out that a new drug chart had not been completed, and as a result, Elise had not been prescribed any Sertraline for several days.

59. I am baffled by why a new drug chart, essentially an item of stationery, could not be obtained immediately from the stationery cupboard or shelves that must surely be present on every ward.

60. In her statement, Dr F says: -

"… *During our ward review on the 29th March 2021, we agreed to change the sertraline back to a total of 200mg as Elise felt that she was not ready to*

switch medications at that point. Unfortunately, due to a prescription error, Elise had a few days when she was not given her sertraline dose when on the ward (30th and 31st and 4th,5th and 6th April), but took it when she was at home during her leave (1st to 3rd April). The error was amended when her mother brought our attention to it the following week."

61. Dr F goes on to state that the missing doses of Sertraline *"could have had an impact on her mood and anxiety levels, although with the number of stressors she was going through, it is hard to tell the impact this had in isolation".*

62. However, I note from the Patient Safety Incident Investigation Report (PSIIR) dated 6 January 2022 that: -

63. *"Evidence states that both stopping and starting can lead to an increase in mental health symptoms (NICE depression in children). Starting is particularly associated with an increase in suicidal ideation. While Miss S reported no change and the Responsible Clinician saw no change prior to 7th April 2021, it was the case that she absconded on 7th April 2021 following a period of reduced medication intake and that her self-harm increased after 7th April 2021 following restarting at the previous dose."*

I will come to the Report later in my statement.

64. The following day (7th April), whilst still on home leave, Elise absconded from an appointment with her community care coordinator, Ms C Elise's grandmother luckily spotted her heading towards the bridge she had jumped

from previously. The police found her, and after an hour of convincing her, Elise was returned to the St Aubyn Centre.

65. Once back at the St Aubyn Centre, a Mental Health Act Assessment was carried out by Dr [redacted].

66. The notes state that Elise *"had went without medication for a number of days and after 2 days she said she felt anxious, her stomach was upset and she feels this contributed to the events of yesterday"*.

67. Reading the assessment note, and knowing what had happened with her prescription, was profoundly distressing for me. It reinforced my fear that the interruption to her medication had a direct and serious impact on her mental state.

68. Elise also said during the assessment that she felt she did not need to be there and would rather come home. Dr [redacted] recorded that Elise did *"not appear to have a rational thought process" or follow "through [on] strategies she has learned so far…"* In any event, Elise was subsequently detained under Section 3 of the Mental Health Act.

69. I understand that the team agreed to complete a referral form for a low secure unit because Elise needed more time in a hospital setting, given the level of risk and her recent suicide attempt. Her next CPA meeting was therefore postponed to the following week to allow Elise time to process what had happened. Elise knew this meant that a transfer to a low secure unit would be explored, and I imagine this would have caused her significant anxiety and added to the distress she was already experiencing at that time.

70. Following Elise's section, Elise was placed back on Level 2 observations. On Longview Ward, Level 2 observations required a young person to be checked six times per hour by a member of staff.

71. This level of observation quickly began to concern me, as Elise was found on several occasions with a ligature tied around her neck. Despite this, and the fact that her care plan recorded an extensive history of using ligatures with various items, such as *"towels, bedsheets and ripped clothing",* Elise remained on Level 2 observations.

72. I recall on one occasion, on 11th April 2021, Elise managed to tie ligatures around her neck repeatedly. When I was informed of this, I immediately raised concerns and told staff I thought Elise needed 1:1 care to keep her safe. I was desperately worried that sooner or later, during a period of acute stress or distress, Elise would succeed in one of her attempts to end her life.

73. When Elise's father raised similar concerns with staff, the response he received was that they simply *"could not hold her hand all of the time".*

74. I understand that our concerns were eventually taken on board, and on 13th April, Elise's observation levels were increased from Level 2 to Level 3 during periods of isolation. Although I was relieved that her observation level was increased, I was concerned that this action appeared to have been taken only after I raised the issue, rather than being identified and implemented proactively by staff.

75. Unfortunately, even with these higher levels of observation, Elise continued to attempt to ligature, even in the ward social area on two occasions.

76. Throughout the admission, between 7th March and 15th April 2021, Elise was involved in 14 incidents involving ligatures. This was deeply distressing for me as her mother, as it showed how unsafe she remained and how vulnerable she was, even while she was in hospital.

77. The entire list of ligature incidents during her admission is as follows:

i. 7/3/21, a loose ligature in her bathroom
ii. 14/3/21 a tight ligature, location not recorded
iii. 20/3/21 reports tying a ligature in her bedspace
iv. 27/3/21 found in bathroom with a tight ligature
v. 28/3/21 ligature found and untied on checks, location not specified
vi. 10/4/21 tight ligature with trousers in bathroom
vii. 10/4/21 ligature with the cord of trousers
viii. 10/4/21 torn blanket (two incidents of ligature on the same Datix) seen on bedroom camera.
ix. 11/4/21 tight ligature in bathroom
x. 11/4/21 tight ligature in bathroom
xi. 13/4/21 ligature in social area
xii. 14/4/21 tight ligature found in “art area”
xiii. 15/4/21 found in her room with parts of a ripped bedsheet

78. These repeated incidents make it clear to me that Elise’s mental health was visibly deteriorating, with a consistent pattern emerging. However, from my

understanding, Elise hardly received any individual mental health therapy during her admission to Longview Ward.

79. Elise had only one session with J on 18th March, during which they discussed the incident on 14th March, when Elise tied a ligature. Despite being offered individual and group therapy sessions, which she often refused, I believe the staff should have actively encouraged her participation, instead of relying solely on medication.

80. A nursing review further corroborates these concerns, noting Elise's fluctuating mood and engagement levels, as well as her tendency to isolate in her room, sleeping and complaining of not feeling well. While Elise was encouraged to participate in activities such as watching films and attending art sessions, these efforts clearly fell short of providing meaningful therapeutic intervention, especially considering the dramatic increase in suicide attempts (8 in the last week of her life).

81. The 'aim' of this admission was, as I understood, to help Elise get better and manage the risks she posed to herself. Above all, it was meant to keep her safe. However, Dr K (Consultant Child and Adolescent Psychiatrist) in his report for the Inquest stated that it was *"unclear what was actually being achieved"* during the admission, and that *"being on a psychiatric ward did not improve Elise's mental state, especially around her ASD."*

82. Due to Elise's autism, she had a black and white way of thinking. It affected how she coped with change, how she processed distress, and how overwhelmed she could become when anxious. In my view, managing a

young person with that level of vulnerability required properly trained, consistent staff who understood autism and how it heightened her risk. Instead, a large number of staff, approximately 40%, were temporary or agency workers. As stated by Dr K, *"Elise was clearly at an increased risk of self-harm and of suicidal behaviour and thoughts as a result of her ASD"* and I do not believe the people responsible for keeping her safe had the specialist knowledge that Elise needed, given how vulnerable she was.

Events of the 17th April 2021

83. On 16th April, Elise phoned me, clearly very distressed after being asked to move bedrooms to the male corridor on the ward.

84. I have since read an entry in the medical records made by L which states: -

"Elise has been quite rude towards staff and at times quite demanding. Much of this seems to surround being moved into another room and she seems unable to accept that in a hospital this is likely. Elise has called her mother demanding that her parents step into this and has been very rude and personal about staff".

85. This entry characterises Elise's behaviour as rude and demanding, but from my perspective, this was a young woman in acute distress, struggling to cope with unexpected change. Her call to me was not about being difficult; it was a plea for help because she felt unsafe and unheard.

86. Dr K described Elise as a *"very poor candidate"* to be moved, given her autism, her dislike of change, and her recent increase in ligature attempts. It therefore seems very clear to me that the staff had little understanding of how Elise's autism affected her ability to cope with change or heightened her vulnerability. Moving any patient on a mental health ward to a corridor for male patients would be unsettling. For Elise, a teenage girl with autism, escalating self-harm and significant anxiety, it was, in my view, wholly inappropriate.

87. Later that day, Elise's father and I visited Elise for her CPA meeting. During the meeting, we were told that a referral to a Low Secure Unit (possibly some distance from our home) would proceed. The notes from the CPA meeting stated: -

"Despite attempts to reintegrate Elise back into the community more quickly, this has not been possible. Elise has had multiple admissions over the last year and has not been able to consistently engage with the community team or make significant changes in inpatient units and continues to present with high risk to herself. Therefore, we will refer Elise to the low secure network to allow Elise the space to do psychology work and to manage her risks in an appropriate space."

88. The meeting was very distressing for Elise, and made it clear to us that she did not want the referral to go ahead. Although we all wanted Elise to get the help and treatment she needed, the thought of Elise potentially being far away from home was terrifying, both for her and us as her parents.

89. The next morning, on the 17th April 2021, I understand from the medical records that Elise was asleep in her bedroom until around 10:30am. When she woke, she went to the ward's social area to have breakfast.

90. At around midday, I visited Elise. I remember she was so happy to see me. Whenever Elise was in hospital, I would always make sure to see her, no matter how difficult my shift at work that day was. We chatted for ages and shared the most beautiful cuddle; there was no better feeling than being with her. I had no idea this would be the last time I saw her alive.

91. After I left, I understand that there was an activity session that evening where patients were able to order a takeaway.

92. The observation records indicate that Elise ate dinner with the other patients in the communal area known as 'The Street' between 17:30 and 18:30. In reality, however, Elise left the social area at around 18:00 and entered her bedroom at 18:11 through an open door.

93. The PSI investigation found that: -

"… the member of staff undertaking the level 2 observations at the time of the incident recorded that Miss S [Elise] had been in The Street (a communal area) at 18:20 when in fact she had been in her room for nine minutes by that time (as indicated by Oxevision footage)."

94. Despite being on level three observations during isolation periods (which all staff were informed about during the shift handover), Elise was allowed to

enter her bedroom alone. To date, none of the staff members present on the day Elise died, has admitted to letting her through the open door.

95. According to data from Oxevision, an 'in-room' alert was triggered at 18:11 when Elise entered her bedroom, followed by an 'in bathroom' notice at 18:14 when she went into her ensuite bathroom. The Oxevision data shows that these alerts were generated from the monitoring station in the nursing office at 18:14:30.

96. However, the PSI investigation found that the sound on the monitor in the nurse's station had actually been muted, meaning that staff did not hear the alarm in Elise's bedroom. I am baffled by how or why a member of staff would mute the alarm on such an important and potentially life-saving piece of equipment.

97. Whilst in the ensuite, Elise ripped her bedsheet and tied a ligature. Nearly 30 minutes later, Elise was found collapsed in her room.

98. I understand there is more than five hours of Oxevision footage of the events as they occurred. To date, I have not seen this footage and do not think I will ever feel strong enough to do so. My solicitors have viewed it, and a timeline was presented to the Inquest. It is very clear to everyone who has viewed it that Elise's death was preventable. In the interest of doing their best to understand how badly (and countless others) have been failed, I very much hope that the Chair and the Inquiry team will watch the footage – I appreciate it will not be easy viewing, but critical if this Inquiry means to ensure that its findings lead to desperately needed improvements in mental health care.

99. A brief chronology of events as per the Oxevision footage is set out below. The imaging has timings included which I understand is correct for the clock duration, but there is a one-hour time difference in the actual time of day: -

17:10:56 Elise appears and then enters the room

17:10:58 Elise enters the open room, shuts the door and enters the bathroom

17:16:32 Elise starts tearing the bedsheet

17:18:52 Elise ties the ligature around her neck

17:21:29 Elise goes from the bathroom to the bedroom and collapses

17:39:28 A member of staff appears at the door window

17:39:45 The staff member enters the room

17:40:27 More staff enter and begin removing the ligature

17:42:10 Resuscitation appears to start

17:43:01 The grab bag arrives

17:52:48 The paramedics arrive

18:27:47 Elise is conveyed to hospital

Emergency response

100. I understand from the investigations that followed Elise's death that the response by staff on finding Elise collapsed was woefully inadequate.

101. Elise was not found by "the first responder" (who we now know is healthcare assistant M until 18:39, 28 minutes after she entered her room. When found, Elise was still alive but unconscious; however, the PSI investigation found that "*there was a delay to initiate resuscitation procedures*" by M, who had not completed

mandatory resuscitation training. M failed even to remove the ligature from Elise's neck.

102. Approximately a minute later, N (healthcare assistant) arrived and removed the ligature. Resuscitation attempts did not start until approximately 18:42. According to N s witness statement, when he arrived, he cut the ligature and *"immediately started CPR (cardiopulmonary resuscitation)".*

103. The PSI investigation found that there was a further delay in contacting the emergency services because the member of staff who made the call did not know they had to prefix the call with a '9'. The call to 999 was therefore not made until 18:43, 4 minutes after Elise was found.

104. The PSIIR states: -

"Not all staff were aware that in order to obtain an outside line, the caller must prefix the call with a (9) so that a call to 999 would need to be dialled as (9)999 in order to be connected. The staff member that made the phone call to the emergency services told the investigation that they had been calling 999 and that they were unaware of the need to prefix 999 with (9) in order to access an outside, external phone line."

105. After the ambulance had been called, it is my understanding that there were delays in administering oxygen. O (the nurse in charge) was the third member of staff to arrive and had brought the 'grab bag' with him. P (charge nurse) and other members of staff from Larkwood Ward then arrived to assist with the CPR. To my dismay, P describes how when she

was looking for the equipment needed, she *"could not make sense of Longview's grab bag, as much of the equipment was spread around the room".*

106. Additionally, **Q** (Senior HCA) described how *"the grab bag from Larkwood was requested, as the contents from the grab bag from Longview had been removed and were on the floor of the bed space so it was difficult to see what we needed".* By the time the additional grab bag was retrieved, a total of around 10 minutes had passed since Elise was found.

107. Although an oxygen cylinder and bag-valve-mask were initially available in Elise's room at 18:42, high-concentration oxygen was not delivered until around 18:49. To make matters worse, even when oxygen was eventually administered, the staff did not have the correct mask.

108. In a further statement submitted by **Q** she states: -

"I communicated with **P** *who was administering oxygen to ES, in relation to CPR and responding to the defibrillator machine. At the beginning of this, initially* **O** *could not find the correct oxygen mask for the tank, he initially said nothing, then when she asked again* **O** *said, "there isn't another one".* **P** *insisted there was. I looked at the mask whilst administering CPR still and I too realised it was also the incorrect mask and the adaptor did not fit the oxygen tank.* **[I/S]** *then found the correct mask and handed it to* **P** *who attached it correctly to the mask and continued to administer oxygen to ES".*

109. The PSII investigation found that the *"delay was contributed to by unfamiliarity with equipment […] and weaknesses in situational awareness and non-technical skills".*

110. The ambulance service eventually arrived at 18:52. According to the Essex & Herts Air Ambulance report, when the paramedics arrived, there was a *"palpable air of confusion and stress"* among staff.

111. In his witness statement, R (senior paramedic) described being delayed in reaching Elise because he encountered a series of locked doors and had to repeatedly attract staff members' attention to be let through. In addition, he described how one of the main priorities for paramedics when they attend an incident of this kind, is information on time scales, as the length of time someone has been ligatured dramatically affects the care provided. However, R described being very frustrated by the little information he was being provided with by staff and was repeatedly told *"I don't know"* or *"I will find out"* when he asked how long Elise had been ligatured.

112. I find it astonishing that staff in a clinical care setting entrusted with maintaining the safety of highly vulnerable patients did not know what they were doing, and this must be addressed as a matter of urgency. Elise had attempted to ligature many times before. Whenever she was at home, she would only do it when she knew one of us was nearby. I truly believe that this attempt was another desperate cry for help and that she wanted to be found. If on 17th April 2021, Elise had not been allowed to go into her room alone, or had the staff found her sooner and performed the correct emergency response, she would still be alive today.

After Elise's death

113. Elise was taken to Colchester Hospital. When I arrived, I was taken to a children's waiting area. I recall a nurse then came out and told me that Elise was having a CT scan, and I knew straight away what that meant.

114. A CT scan was carried out, which showed brain swelling and a diagnosis of hypoxic ischaemic cerebral insult.

115. Elise was transferred to the intensive care unit, where she was put on a ventilator. At some point, the sedative medication that she was being given was discontinued to allow an assessment of her neurological status.

116. We were told that the tests confirmed that Elise was brain dead.

117. Those were the worst days of my life. I stayed by Elise's bedside and held her hands for days. Two days later, it was determined that nothing else could be done, and on 19th April 2021, the ventilator was switched off. Elise passed away a short while later.

118. I don't think the image of Elise lying there with tubes and monitors attached to her will ever leave me. Elise was supposed to be on 1:1 care. I could not comprehend how this could have happened; they were supposed to be looking after her.

119. The post-mortem conducted by Dr S found the cause of death to be 1a) Hypoxic brain injury, 1b) Compression of the neck by ligature.

Investigations

PSIIR:

120. The Trust produced a Patient Safety Incident Investigation report on 6 January 2022. The report (57 pages) identified 17 what they describe as *"system/process weaknesses".*

121. The main "*weaknesses"* found in the investigation are listed below (the full list can be found in the report):

i. *"There was an expectation for bedroom doors to be locked whilst rooms were not occupied. The investigation found there was no effective system in place to achieve that aim. […] This weakness in process led to Miss S having been able to gain access to her bedroom and therefore acted as a missed opportunity in preventing the incident…"*

ii. *"The investigation found that at the time of the incident neither CCTV nor bodycams were in operation. The lack of CCTV footage led to a missed opportunity when staff may have been able to see that Miss S was walking around the unit without supervision and may have been able to prevent her walking into her bedroom alone…"*

iii. *"Technology limitations also impacted on the ability for early detection of the incident. Due to wifi connectivity problems, the Oxevision*

tablets (monitors) were not functioning and were not being carried around the ward by the person undertaking level 2 observations."

iv. *"The investigation found that at the time of Miss S accessing her bedroom alone, there were a total of 11 patients on level 2 observations and all were being observed by one member of staff per hour […] As the requirement was to observe patients on six occasions over 60 minutes, the member of staff was required to observe a different patient every 54 seconds; to meaningfully engage with them; and to write up an observation record. This investigation concluded that this volume of patients to be observed was a near impossible task for a single member of staff…"*

v. *"The investigation found that Miss S had access in her room to pens and pencils […] It was not clear to the investigation whether an appropriate risk assessment had been undertaken to consider the risk".*

vi. *"Miss S had been prescribed mixed observation levels – level 2 in social areas and level 3 in isolated areas. […] The investigation found that whilst Miss S had been in her room at the start of the day, a staff member had been allocated. However, once Miss S had joined the social area had she then wished to return to her bedroom, the allocation of a level 3 observations duties would have been on a random ad-hoc basis."*

vii. *"It is noted that staffing levels during the shift were appropriate…"* However, *"almost 50% of staff on shift were new to the ward and*

unfamiliar with patients. They also would have been unfamiliar with their roles in the unit. During interviews, staff reported to the investigators that roles of temporary staff were ill defined with little direction of the activities in which staff should be engaged at all times".

viii. *"The investigation found that the activity session on the evening of 17th April 2021 involved the patients choosing takeaway food options and eating together. This led to the only permanent member of staff in 'The Street', being required to answer the main door to the building on many occasions to accept meals […] During this period, the staff who were with the majority of patients were temporary staff who neither knew the patients well nor had clearly identified roles…"*

ix. *"In relation to the response to the emergency situation and resuscitation attempt, numerous systems and processes did not align with the Resuscitation Council UK Quality Standards: Mental health inpatient care"*

x. *"From the 12 staff members listed on the Datix electronic incident report as having been involved in the incident, mandatory training records indicated that four staff were either nor compliant or had either not completed mandatory resuscitation training (known as 'drab bag training'). Two additional staff could not be found in the system, indicating that there was no assurance that they were compliant".*

122. The report goes on to make 11 recommendations, with the main ones listed below:

i. *"The investigation recommends that a robust system is put in place which prevents unauthorised access to patients' bedrooms. Ideally, this system might include mechanical (ligature safe) self closure system or be technological, but essentially it should not rely on human memory in order to be effective".*

ii. *"The investigation recommends the delivery of effective engagement and supportive observations procedures, including the consideration of electronic observation technologies and the use of Oxevision tablets (monitors) whilst undertaking level 2 observations."*

iii. *"The investigation recommends a review of the format of handovers to increase staff members' awareness of risk, observation levels and their responsibilities for each patient".*

iv. *"The Trust aims to provide twice-yearly simulation/scenario training on every ward but has not always been able to achieve this target. It was reported to the investigators that staff consider twice yearly insufficient for high risk wards. Therefore, the investigation recommends that the Trust reviews its provision of resuscitation process and training in order to:*

1) Align it to Resuscitation Council UK (RCUK) standards (Resuscitation Council UK Quality Standards: Mental health inpatient care);

2) Adopt (ILS) course as a minimum standard for staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion;

3) Ensure that simulation cardiac arrest/resuscitation drills occur at least quarterly on Longview Ward and Larkwood Ward."

123. I do not know if any of these recommendations have been implemented. The fact that there have more deaths since Elise, suggests not.

124. The report concluded that Elise: -

"[…] had serious, persistent and fluctuating mental health difficulties with diagnoses of Autistic Spectrum Disorder, depression and anxiety, and physical health worries. Multiple historic and recent causative factors would have affected her mental health. Her mental health had previously stabilised in hospital, but she was vulnerable to stress. Multiple admissions to hospital have the potential to worsen mental health through various mechanisms. The change in medication, discussions about a low secure referral, and changes in home life may all have contributed to increased risk. The risk of [Elise] to herself was recognised by parents and staff and acted on by increasing observations, but there was a failure to carry through the care planned observations."

Oxevision

125. Before Elise was hospitalised, I knew very little about Oxevision. I remember Elise mentioning that some of her friends on the ward felt like they were being watched by 'Big Brother,' but I just thought the technology was in

place for their safety. Now, after Elise's death and the investigations that followed, I have concerns about the technology and how reliable or suitable it really is.

126. As I have already mentioned, the Oxevision alert (the audible sound) had been muted at the time of Elise's incident. Staff in the nursing office, therefore, did not hear the alarm and were not aware that Elise was in her room alone. In the Standard Operating Policy (SOP) for Oxevision, there is no indication that there is a functionality or reason to mute the sound on the monitors. Although the PSIIR recommends that the policy be reviewed *"to include that sound should not be muted from the Oxevision monitor"*, I am baffled as to why this was not already in place or why someone was able to mute it in the first place.

127. Moreover, the PSIIR goes on to state, *"a senior leader within EPUT reported that they attended Longview Ward the day after the incident and found that the Oxevision monitor had been muted. They were able to manually turn the volume back on and noted that it could only have been turned off on the monitor itself"*. I am shocked to find out that the sound was still muted the day after Elise's death.

128. In addition, the PSI investigation also found that the Oxevision tablets were not in use at the time of Elise's incident due to *"wifi connectivity issues"*. The PSIIR also states that the *"investigation also found that at the time of the investigation team's sight visit on 4th September 2021, they (the tablets) were still not being utilised effectively"*. It therefore seems to me that there needs to be a serious and thorough review of the use of the technology, as it does

not appear to be used correctly, if at all, by staff, potentially placing many more lives at risk.

Police Investigation

129. After Elise's death, the police, led by DI T investigated possible offences of Gross Negligence Manslaughter and Corporate Manslaughter against the Trust. To our dismay, we were informed that no action would be taken.

130. We therefore requested a 'Victim Right to Review' on 28th September 2024. To our further disappointment, Detective Chief Inspector U upheld the decision and confirmed that no further action would be taken.

131. However, DCI U had recommended that the police suspend the formal closure of the criminal investigation until the conclusion of the Inquest, and that they would consider any new information that might affect the decision. This left us with a glimmer of hope.

Care Quality Commission (CQC) Inspection

132. On 11th May 2021, following Elise's death, an unannounced inspection was carried out. As a result of this inspection, Section 31 of the Health and Social Care Act (2008) was invoked, which required the restriction of all admissions of new patients to EPUT's three Child and Adolescent Inpatient wards without the prior written agreement of the CQC. In addition, a condition was made that staffing levels on all three wards should meet the required

numbers of suitably skilled staff to meet the patients' needs and to undertake patient observations as prescribed.

133. At the time the PSII report was written, s.31 was still in place. However, I do not know whether this is still the case.

Inquest and civil claim

134. A gruelling four-week Article 2 Inquest took place between 29th April to 28th May 2025. Ahead of the Inquest on 5th March 2025, EPUT made an admission. The admission stated: -

"The Trust failed in its responsibilities towards Elise on 17 April 2021 by allowing her to leave "The Street", enter her bedroom through an unlocked door, and remain in her bedroom without staff supervision.

Elise should not have been able to leave The Street and enter her bedroom unsupervised. The doors between The Street and Elise's bedroom, including the bedroom door itself, should have been locked to prevent access to the room without a member of staff being present. It is accepted that the bedroom door had been open since at least 16:00 on 17 April 2021 and this allowed Elise to gain entry.

The Trust accepts that these failings were causative of Elise's death on 19 April 2021."

135. The jury concluded that there were numerous failings in Elise's care and treatment and that her death was contributed to by neglect on the part of the Trust.

136. The jury's conclusion was: -

"We the jury unanimously agree that Elise's death could have been prevented or her life prolonged if not for the multiple failings in her care whilst at St Aubyn's. We found two main factors that probably caused her death; the first being poorly administered observations due to poor staffing levels and falsified information on observation forms. The second being Elise being able to gain access to her room and her observation level in an isolated area not being considered which directly led to Elise tying the fatal ligature. The evidence does show that Elise's death was contributed to by neglect."

137. A prevention of future deaths report was produced by the Coroner and provided to us on Tuesday, 10th February 2026 – nearly 9 months after the Inquest had finished. The Coroner's concerns are stark and demonstrate just how seriously Elise was failed. I have listed the concerns below: -

"1. Mental Health Trust Staff on Longfield Ward:

a. *Elise was neurodiverse, and staff were not trained in autism.*

b. *were inexperienced. The majority were new bank and agency staff with limited experience working with detained children, and this matter had been raised by the Care Quality Commission about other Trust services in January 2021.*

c. *Did not have sufficient staffing to conduct observations required by the doctors for patients on the ward. This was known to the mental health Trust management and had been*

raised by the ward manager. During the time of Elise's admission, the staff member allocated for observations for patients was required to conduct approximately 66 observations within an hour. This was not logistically possible. Management knew that staffing allocation on Longview Ward was not sufficient to conduct the required levels of observations to keep the patients safe. Evidence was heard during the inquest that there are still observations that are not being conducted either as required or at all within the Trust and remains an ongoing concern. Datix reporting incidents are not always raised.

d. *The mental health Trust implemented a system called Oxevision with a Project Board to assist with the planning and roll out of the new system. There were difficulties with the roll out on St.Aubyns ward who were part of the pilot, due to WiFi coverage and the Oxevision system not operating correctly.*

e. *The clinical management at the Trust Project Board meeting overseeing the roll out for Oxevision, required that ward staff implement a procedure where the Oxevision fixed monitor in the ward office be observed by a member of staff whilst the WiFi problem was resolved. This did not happen on Longview Ward.*

f. *The Trust Project Group had reports that WiFi was not working and any issues were required to be reported as incident reports on Datix forms but these were not being completed.*

The Trust Project Board did not question why they were not receiving the Datix forms with the known issues. There was no oversight of what was required to ensure that the roll-out was operating appropriately and/or what the Project Board expected in the interim whilst the WiFi difficulties were being investigated.

g. *Not all the Trust staff on the ward were trained to use the Oxevision System.*

h. *There was disputed evidence about the volume on the fixed terminal for Oxevision in the office about whether the alert volume could be turned down or 'muted'. It was established that there was an incident unrelated to Elise's death where a doctor did turn this volume down on the ward."*

"2. Elise's medication changes whilst in mental health hospital were not correctly entered onto the medication chart:

a. *Elise asked for changes to her medication and then reported that these changes were not therapeutic. It was agreed with her consultant that her previous regime would be implemented. The medication was crossed out and removed from the prescription chart. Sertraline 200mg was re-prescribed by the consultant but not entered onto the medication chart and not administered.*

b. *Nursing staff did not query the sudden cessation of medication for treating mental health with no replacement or explanation given. Elise suffered a significant deterioration in her mental health during this time, the frequency and severity of ligatures increased, and Elise had to be placed under section 3 Mental Health Act.*

c. *There was no pharmacist scrutiny just prior to the Bank Holiday and the medication error was only noted when questioned by Elise's family when she went on home leave.*

"3. There was poor communication between ward staff and vital information about self-harm and ligaturing was not handed over on shift change. It was undisputed that Elise tied 12 Ligatures between 7th and 14th April and that she was found in the presence of ripped bedding on 15 April. The Datix incident recording gave minimal details and only the ligatures from the 13th and 14th were recorded on the whiteboard in the nurse's office."

"4. Mental Health Trust staff falsified Elise's observation records and this was not identified by the Trust post-death investigation despite the availability of timings from Oxevision imaging. This matter arose in an inquest that significantly post-dated Elise's death and there is concern that lessons had not been learned. The Trust internal investigation does not refer to this and these matters are arising with scrutiny within the inquest hearing."

"5. The observation level for each young person is decided by the medical staff at the Trust and can be altered dependant on the patient's risk level. The Trust Policy had a protocol on how observations should be conducted.

All observations should be recorded by the staff on formal observation sheets. There were sheets for Level 1 and another sheet for the levels 2,3 & 4. Risk assessments were incomplete and not all ligatures were included The entries in the records were not all consistent, some contradicted others and this included the levels of observations required to keep Elise safe on the observation charts that were required to be completed. This was confusing and remains a concern as these are entries made by qualified Trust staff who have received training in observations. During the Trust internal investigation after Elise's death, the investigator visited the ward and found observations were not being conducted in accordance with the Trust Policy."

"6. Detained patients including Elise were not kept under observations by trained staff and mealtimes were chaotic with patients moving between areas without the required supervision. On 17 April the activity co-ordinator left a box of mobile phone chargers and headphones that posed a ligature risk, with a member of ward staff in a communal area, asking that she look after this whilst he collected some takeaway food that had been ordered by patients from the ward entrance. On his return, the box was unattended in the presence of patients with a high risk of ligature and suicide, with no member of ward staff present to keep patients who required level 2 and level 3 observations. This was not reported to the nurse in charge, and no incident report was completed. Evidence was that there were many new staff and that breaches of procedure were a regular occurrence. This left patients at risk. Evidence was heard that patients are still being left without the required observations since this death."

"7. Oxevision imaging showed Elise entering her bedroom alone at approximately 18:10 hours and she remained in her room until she was found unresponsive at approximately 18:29. Elise's observation logs for 17:30-18:30 on 17 April were falsified recording that Elise was in the communal area with checks completed at 17:30 17:40 17:50 18:00 18:10 and 18:20 recorded that Elise was present in the communal area. Elise was required to be on constant eyesight observations whilst in her bedroom."

"8. The mental health Trust were on notice that staff must have falsified the observations logs for Elise in 2021. Another inquest for a St. Aubyn's patient who died on 12 July 2022, also found that observation logs were falsified and contained errors. Trust staff falsification of records were not further investigated or monitored after Elise's death at St. Aubyn's Centre."

"9. Elise's key nurse was working nights and was not having the required 1:1 with Elise and key documents were not completed for Elise's care. Inaccuracies and inconsistencies in record-keeping remains a concern."

"10. Whilst this did not directly cause Elise's death, there were plenty of staff who responded quickly to the emergency when Elise was found unresponsive but there was a delay:

a. *bringing the grab bag to this emergency*
b. *obtaining and attaching the defibrillator.*
c. *In notifying the duty doctor who was not contacted for over 40 minutes.*
d. *The expert witness was of the opinion once the defibrillator was attached, it was being switched on and off in the first few minutes. When looking at the machine analysis there appeared to be 3 analysis checks on the*

machine within the first few minutes when the machine is set to conduct analysis at set intervals which is inconsistent with this."

138. A clinical negligence claim was successfully brought against the Trust. The case was settled at the end of 2025. Elise's father and I pursued this primarily for the benefit of Elise's siblings, and our only hope now is that the Trust take serious action and learns from the long list of mistakes.

Request to Essex Police to reopen their investigation into Elise's death

139. Following the Inquest and the shocking evidence heard, my legal team agreed with Elise's father and me that the initial Police investigation was inadequate. Accordingly, a lengthy letter setting out the evidence that emerged during the Inquest was sent to Essex Police on 3rd October 2025.

140. On the 22nd December 2025, we received a response from the police that was underwhelming and wholly disappointing, to say the very least. The letter stated how *"the evidential test required to prosecute offences of gross negligence manslaughter or corporate manslaughter remains unmet",* and that the investigation would not be reopened.

141. As the Chair may be aware, last year a seven-month trial took place at the Old Bailey concerning the death of Alice Figueirdo, an inpatient at Goodmayes Hospital. NELFT was charged with corporate manslaughter and, after 24 days of deliberation, the jury found the organisation criminally liable for breaches of health and safety. The fact that the Crown Prosecution Service considered there to be a more than reasonable prospect of securing a conviction in Alice's case highlights the seriousness of the failings involved.

Sadly, Elise's circumstances are very similar. We therefore feel that we have been entirely let down by the police and are unable to understand how, given the circumstances of Elise's death and the several gross failings found, it does not meet the threshold required for a criminal prosecution.

142. We now look to this Inquiry to deliver answers and to ensure that those responsible for failing our daughter are ultimately held fully accountable.

The lasting impact

143. This Chair and the Inquiry Team will have read and heard the accounts of so many bereaved parents and families that I daresay each account must begin to sound the same.

144. I do not know what words to use to try to convey the enormity of our loss. We were a very close family. Each of us have been left utterly traumatised and bereft. In addition to my own overwhelming and at times mind-numbing grief, I have had to watch the toll that Elise's death has taken on each of her siblings.

145. None of us is the same as we were before her death. We all continue to function, each in our own way, as best we can, but our lives have changed irrevocably, and the pain we are left with will be with us forever.

My views and recommendations for change

146. I am sure that my comments and suggestions for recommendations will echo those of all the bereaved families who have already given evidence. Certainly, I concur with all the recommendations suggested to date.

147. For what it is worth, I have set out below what I think are the most important and pressing changes that need to be made – some are urgent and need to be implemented immediately, ideally by way of an interim recommendation, others, as important by perhaps not as critical, can follow.

148. All staff must undergo comprehensive training that covers essential aspects of physical health care and CPR. This training should be thorough, ongoing, and regularly refreshed to ensure that staff remain knowledgeable and prepared to respond effectively in emergency situations.

149. A thorough review of the use of Oxevision and whether it is appropriate to use within mental health wards should be undertaken. At the very least, clearer information should be provided to families and patients regarding the use of Oxevision, and informed opt-in consent should be obtained as soon as a patient is admitted.

150. Patients should be fully informed about all available treatment options.

151. Families should also be kept in the loop with the decision-making process.

152. A continuous and thorough review of a patient's physical health needs should be maintained throughout their admission. Physical health issues are frequently overlooked or ignored, yet they can significantly impact and

potentially worsen a patient's mental health if not properly identified and managed.

List of Documents which I have:

Please see Appendix A

Statement of Truth

I believe the content of this statement to be true.

SIGNED [I/S]

MS VICTORIA SEBASTIAN

DATED 9th March 26.

APPENDIX A – LIST OF DOCUMENTS WHICH I HAVE

I. Inquest bundle

i. Statements

1) [I/S] (Executive Chief Operating Officer), 07/05/2025
2) [I/S] (Senior Healthcare Assistant), 17/07/24
3) [I/S] (Healthcare Assistant), Undated
4) (Healthcare Assistant), 07/04/22
5) (Bank Staff), Undated
6) (Bank staff), 14/04/25
7) (Clinical Lead), 06/11/22
8) (Clinical Lead), 08/12/22
9) (Clinical Lead), 03/03/25
10) (Clinical Lead), 22/04/25
11) [I/S] (Mental Health Nurse), 07/04/22
12) [I/S] (Healthcare Assistant), 12/04/22
13) (Healthcare Assistant), 12/11/24
14) [I/S] (ITT Directorate), 05/02/25
15) (ITT Directorate), 07/02/25
16) [I/S] (Detective Constable), 07/03/23
17) [I/S] (Mental Health Nurse), 07/04/22
18) [I/S] (Charge Nurse), 12/12/24
19) [I/S] Healthcare Assistant), 07/04/25
20) (Family), 28/04/25
21) [I/S] (Engineer), 08/04/22
22) [I/S] (Associate Director), 31/03/25
23) [I/S] (Care Co-Ordinator), 27/03/25
24) [I/S] (Head of Records Management), 08/05/2025
25) [I/S] (Senior Healthcare Assistant), 14/06/21
26) (Senior Healthcare Assistant), 21/11/24
27) [I/S] (Head of Patient Safety & Quality, Oxehealth), 27/11/24
28) [I/S] (Assistant Psychologist), 05/02/25
29) [I/S] (Prehospital Doctor), 11/01/22
30) (Service Manager), 25/04/25
31) (Service Manager), 07/05/2025
32) [I/S] (Senior Director of Estates & Facilities), 06/02/25
33) [I/S] (Healthcare Assistant), 04/04/22
34) [I/S] (Senior Paramedic), 02/09/22

35) [I/S] (Activity & Engagement Co-Ordinator), 29/04/22
36) [I/S] Psychologist), 05/11/24
37) [I/S] Psychologist), 25/02/25
38) [I/S] (Charge Nurse), 07/02/25
39) [I/S] (Healthcare Assistant), 19/05/22
40) [I/S] (Clinical Lead), 10/06/21
41) [I/S] (Doctor), 26/11/21
42) [I/S] (Doctor), 22/12/22
43) [I/S] (Psychiatrist), 27/03/25
44) Victoria Sebastian (Family), 23/04/21
45) Victoria Sebastian (Family), 23/04/25

ii. Medical Records

1) East of England Ambulance Service
2) East Suffolk and North Essex Foundation Trust
3) Essex Partnership University Trust
4) NELFT EWMHS
5) Trinity Medical Practice

iii. Reports

1) CQC Inspection Report, 14/01/21
2) CQC Inspection Report, 15/09/21
3) [I/S] (Expert in Intensive Care Medicine and Resuscitation), 02/04/25
4) [I/S] (Consultant Child & Adolescent Psychiatrist), 16/04/25
5) Patient Safety Incident Investigation (PSII) Report, 06/01/22
6) Post-mortem report by Dr [I/S] (Consultant Histopathologist), 26/04/21
7) Post-mortem report by Dr [I/S] (Consultant Histopathologist), 07/06/21
8) Toxicology report by [I/S] (Consultant Clinical Scientist), 04/06/21

iv. Policies, Procedures, Training and Other Documents

1) CAMHS Inpatient Operational Policy, EPUT, October 2021
2) Cardiopulmonary Resuscitation Procedure, EPUT, August 2017
3) Clinical Guideline for Clinical Handover, EPUT, May 2018
4) Clinical Guidelines on the Prevention of Suicide, EPUT, July 2017
5) Clinical Risk Assessment and Safety Management Policy, EPUT, 01/07/2017

6) Clinical Risk Assessment and Safety Management Procedure, 01/07/2017
7) CPA Policy, EPUT, 01/07/2017
8) CPA Procedure, EPUT, 01/07/2017
9) Deployment of Temporary Workers Policy, EPUT, April 2017
10) Deployment of Temporary Workers Procedure, EPUT, April 2017
11) Engagement and Supportive Observation Trustwide Policy, EPUT, 30/03/2018
12) Engagement and Supportive Observation Trustwide Procedure, EPUT, 20/03/2018
13) Induction, Mandatory and Essential Training Policy, April 2017
14) Ligature Risk Assessment & Management Policy, EPUT, March 2019
15) Ligature Risk Assessment & Management Procedure, EPUT, March 2019
16) Managing Temporary Worker Conduct and Complaints Policy, July 2018
17) Managing Temporary Worker Conduct and Complaints Procedure, EPUT, July 2018
18) Oxevision footage, 17/04/21
19) Search Policy, EUT, March 2018
20) Search Procedure, EPUT, March 2018
21) Standard Operating Procedure for the use of Oxehealth's Oxevision, 20/04/21
22) 999 Call transcript, 17/04/21

II. Inquiry bundle

i. Statements

1) Victoria Sebastian Commemorative Statement,

III. Documents held by our client

i. Police

1) Letter from the Police, 19/04/2024
2) Letter from the Police, 22/12/2025
3) Victim Right to Review Outcome, 28/09/2024