

**WITNESS STATEMENT OF LISA WOLFF, PURSUANT TO RULE 9 REQUEST FROM THE
LAMPARD INQUIRY**

1. I, Lisa Wolff [I/S] am the mother of the late Abbigail Louise Smith (born on 23 June 1995; died on 16 February 2022).
2. I am making this statement based on my memory of events, from having seen my late daughter's records / other disclosure and from having attended the Inquest into my daughter's death.
3. I reserve the right to make a supplementary statement based on further disclosure obtained by the Inquiry and disclosed to me in due course.
4. The concerns raised from my daughter's care are such that a civil claim is also being pursued.
5. Abbi had been diagnosed with autism, learning difficulties and mental health problems. She spent a large portion of her life in psychiatric institutions. This statement will show that in my view these institutions struggled and failed to treat her - they did not look at her mental health concerns in context of her autism and learning difficulties.
6. I have recently also been diagnosed with autism. I would like to highlight the fact that women and girls with autism can present very differently to that which is often expected or seen as 'the norm'. In my view, the issue was always that no one could see Abbi's disability, and I feel that it was completely ignored. I used to call it her 'double edged sword'. I called it this as people would comment that you couldn't see her disability. This was both a blessing and a curse as people did not comprehend the level of support she needed or the depth of her disability.
7. In addition, my therapist believes that I have PTSD – in my view this is as a consequence of the trauma that Abbi and I went through whilst Abbi was under the care of the psychiatric services.
8. As explained later in my statement, Abbi spent an enormous proportion of her life in various types of psychiatric institutions. Given that she died at the age of 26, this meant that much of her adolescent years were spent in such institutions.

Outline

9. From memory by the age of approximately 5 years old Abbi was diagnosed with:
 - o Learning difficulties (I believe this was diagnosed by the paediatric department, Stepping Hill Hospital, Stockport). We were seen in a satellite clinic for this appointment in Marple Health Centre.
 - o Speech and language processing disorder. This diagnosis was given by a speech and language therapist at Marple Health Centre.

10. She was diagnosed with dyspraxia and sensory processing disorder when she was approximately 7 / 8 years old - I think she was diagnosed by someone who visited us from the autism support service in Stockport (the name of the service escapes me).

11. Abbi was diagnosed with autism.

12. Whilst in Stockport – I believe it was 2005 / 2006. I believe that Abbi's autism was diagnosed by **Speech & Therapist CAMHS** who, from my understanding still practices and has now become a specialist. Abbi saw **that** (Speech & Therapist CAMHS) and Dr **[I/S]** at Stepping Hill Hospital in Stockport. Dr **[I/S]** was a Consultant Child & Adolescent Psychiatrist. Report prepared by Dr **[I/S]** dated 18.05.06 states:

“...INTRODUCTION

*Abigail was referred to Stockport CAMHS by Dr **[I/S]** in July 2004. Abigail's learning difficulties & speech & language delay were recognised problems, for which she was receiving support. However, Dr **[I/S]** raised concerns about Abigail possibly having a mood or anxiety disorder & social communication difficulties. Abigail's habit of harming herself by biting herself was also raised as a concern. During the CAMHS assessment Abigail has been diagnosed as having Autism. This CAMHS report has been prepared at parent's request due to their high level of concern about how Abigail will cope with transition to high school. Professionals involved share this concern...*

Abigail has a complex neurodevelopmental disorder including learning difficulties, Autism, speech & language delay & motor coordination difficulties. Abigail still has very significant difficulties with her verbal skills & social skills.

Abigail has only recently received a diagnosis of Autism, despite longstanding concerns from the parents. In the past Abigail's social difficulties have been attributed to her speech & language delay, but this does not account for the level of difficulty she has with social relationships. It is well recognised that the diagnosis of autism is often missed or delayed in females, as their presentation often includes superficially appropriate social skills. In fact, the ADOS assessment revealed that Abigail has very significant difficulties in addition to speech & language delay. Teaching & support staff need to be aware of Abigail's diagnosis, particularly in view of the subtle presentation, & to have skills in working with children with Autistic Spectrum Disorders.

Abigail suffers from social anxiety, this is secondary to her speech & language delay & autism, & adds to her disability. Her anxiety has become more apparent as the demands of the curriculum & social demands have become increasingly complex. Abigail is very likely to find high school even more anxiety provoking. When she is anxious she becomes more rigid in her style of thinking & is less able to cope with change. We would recommend that Abigail will need support for breaktimes & lunchtimes in addition to class work to manage social demands due to her complex difficulties. In the past Abigail has tended to become very fixed on an individual peer & this is not always welcomed by the peer, nor is it appropriate. She has great difficulty reading social cues & interpreting facial expression & body language. She will need guidance to find a suitable & supportive peer group & to sustain friendships. She has had input from primary Jigsaw (Community CAMHS) for friendship skills, but needs additional work in this area.

Abigail takes a considerable amount of time to trust new people & gain confidence in social interaction & conversation with them. It is therefore advisable that she has consistency in the members of staff supporting her. Abigail's conversational skills are currently very limited & she needs lots of opportunities to practice these skills with staff on an individual basis.

Abbigail is very dependent on classroom support for her learning. Without classroom support she is particularly vulnerable, as she does not ask or signal for help even though she often struggles to understand whole-class verbal instruction & written instructions. This particular feature of Abbigail's presentation has been noted by her teachers at Primary School and by the CAMHS team during her day assessment here. Abbigail has already developed a range of strategies to avoid doing work that she is likely to use if not adequately supported. She is likely to struggle with all subjects that have a high language content & the language demands of the curriculum need to be carefully monitored.

Abbigail's speech & language skills are linked to a central auditory processing problem. Abbigail needs a high level of individual support because she needs verbal instructions to be broken down into small chunks, she needs repetition of instructions, she needs to be addressed in concrete terms (due to pragmatic difficulties), she needs visual queues and she requires thorough over-learning. If there are any lessons where she is not supported & these requirements for her understanding are not met, she will not be able to access the teaching in that lesson.

Abbigail has very little awareness of danger & is socially naïve & easily led. She has been to A&E on many occasions in the past with significant injuries as a result of impulsive & unthinking actions. She has very little awareness of pain. This has been a concern at Primary School & will be more of a concern at High School when she has access to much older & more sophisticated peers in the unstructured parts of the school day.

Abbigail has had cyclical bouts of low mood lasting for a few months at a time over the last few years. This is accompanied by deterioration in sleep, increased anxiety, fatigue, irritability & social withdrawal. At these times she will hurt herself by hitting, scratching, pinching, & biting herself.

These bouts of low mood in the past appear to have occurred in the summer when she becomes aware of peers playing outside together, & her own limitations with peer interactions in comparison. **It is well recognised that young people with Autism are prone to developing mood & anxiety disorders in the first year or so after transition to High School, particularly when they are inadequately supported.** Young people like Abbigail who also have a history of mood disorder, are at a higher risk of having an episode of mental illness after transition..." (emphasis added)

13. This diagnosis was reconfirmed in the NEPT CAMHS Neuro-developmental and cognitive assessment dated 2010 - 2011 – report by Dr [I/S] (Chartered Clinical Psychologist) and [I/S] (Assistant Psychologist). This report states Abbi was given a Verbal Comprehension Index score of 61, which gave her a percentile rank of 0.5, which was stated as "extremely low". Abbi was also given a Full-Scale IQ of 68 which placed her on the percentile rank as 2, again stated as extremely low range.

14. A subsequent letter from Dr [I/S] Pennine Care NHS Trust, dated 18 August 2006 states:

"... Abbigail has tolerated Fluoxetine at 20mg once daily ...I have given parents information about National Autistic Society seminars ..."

15. CAF Form – Common Assessment Framework for children and young people, dated 15 May 2009, includes:

"... Lisa referred Abbigail to the Children with Disabilities Team as she wished to access services for her daughter who has a diagnosis of autism. An initial assessment was undertaken by a senior practitioner and Abbigail Smith was given direct payments to enable her to access

social activities. Mrs. Smith later contacted the department as she was concerned about the lack of services involved with her daughter...

Abigail has a statement of special educational need and has a full time support worker at school. Hylands Secondary School Hatfield Grove Chelmsford...

Abi is a teenage girl with a diagnosis of autism. Abi does not accept that she has a diagnosis of a disability therefore often does not engage with me as she is aware I am from a children with disabilities team. Abi presents well and does engage in conversation though it is unsure how much she processes and understands. Her responses are often short and limited. On numerous visits Abi has gone up to her bedroom.... Ms Smith expressed that Abi use to self harm, though there have been no signs of this throughout the assessment. There is a risk of Abi's behaviour escalating if preventative support is not implemented. Abi would also benefit from some long term one to one support to aid her Independence regarding money, career, school, friendships and social awareness...

Ms Smith would like Abi to be more self aware, confident and be more aware of dangers and consequences of her actions. Ms Smith acknowledges that Abi is developing in to a young women and is concerned about her interaction with boys and her being easily led.

Ms Smith also would like Abi to have a mental health assessment (CAHMS). I have advised Ms Smith to seek support from her GP.

Ms Smith would also like Abi to have an educational psychologist involved to support her learning and behaviours at school. Ms Smith is to liaise with the school regarding this.

I feel Abi would benefit from an intense personal advisor from connexions to undertake some self esteem and confidence work with Abi and also to support her throughout her teenage years to become more independent and to support her into adult life. This would also give Abi a consistent one to one where she can build up a trusting relationship and hopefully be able to explore 'autism' and what this means to Abi and how this impacts on her life..."

Mental health

16. Abbi began self-harming from a young age, approximately 3. She would peel the skin from her fingers and would wrap cotton around her toes. Things had escalated by the time she was about 5 or 6 to throwing herself downstairs and both biting and hitting herself. Abbi first saw a psychiatrist for her diagnosis of autism. She was kept on the caseload of the clinician, Dr [I/S]
17. We moved to Essex in 2007 (when Abbi was about 12 years old) and SENCAN informed us that there would not be as much support available in Essex. In my view I would say that Abbi went from having full time support in school to none that was worthwhile. SENCAN stands for Special Educational Needs and Children with Additional Needs - and this department was part of Essex County Council.
18. Her mental health deteriorated, and police were called when she absconded from school. School excluded her and told me this was to help her to be placed more appropriately in an education setting that could support her. Her SENCo (Special Educational Needs Coordinator) wrote to two schools [I/S]. One rejected her as they thought her symptoms were too severe and the other accepted her. Abbi appeared to enjoy her new school.
19. Abbi was prescribed antidepressants to support her move from primary to secondary education. However, her mental health declined again. Around 2009 / 2010 (when she was about 14 /15 years old) Abbi was referred to CAMHS and had outpatient appointments in Chelmsford. Abbi had started to draw pictures of graves putting holly in her shoes and writing wills leaving her belongings to

others. She was also burning herself with an aerosol can and attempted to ligature. I asked for support from school and Abbi was referred to the St Aubyn Centre. [U/S] a psychologist, came out to assess Abbi.

20. She was admitted to Longview Ward in the St Aubyn Centre in 2012 (when Abbi was about 17 years old). I was told that this would be a two-week intervention to support her with her mental health and with the way she struggled to understand her autism. The school had specifically mentioned to the St Aubyn centre that she needed help to understand her autism. When Abbi was admitted she went in with the things that she found supportive such as her squeeze jacket, weighted blanket and vibrating cushion.
21. As mentioned above, Abbi spent a huge amount of her life in institutionalised care. The Patient Safety Incident Investigation Report Version 2 approved 30 November 2023 ("PSII"), contains the following table showing admissions from 2012 – 2017.

<i>"Date of admission"</i>	<i>Date of discharge</i>	<i>Ward</i>	<i>Reason for admission</i>
<i>2nd July 2012</i>	<i>13th February 2013</i>	<i>Longview (CAMHS), EPUT</i>	<i>Low mood, suicidal ideation and self-harm. Overdose</i>
<i>13th February 2013</i>	<i>24th September 2013</i>	<i>Larkwood (CAMHS), EPUT</i>	<i>Transferred from Longview to Larkwood There were several incidents of self-harm and ligature during this admission. She was considered for a personality disorder unit.</i>
<i>24th September 2013</i>	<i>30th January 2014</i>	<i>Christopher Unit, EPUT</i>	<i>Transferred when she turned 18</i>
<i>5th October 2015</i>	<i>20th October 2015</i>	<i>Chelmer Ward, and The Priory, Chelmsford</i>	<i>Overdose</i>
<i>20th October</i>	<i>25th January 2016</i>	<i>Galleywood Ward, EPUT</i>	<i>Transferred from The Priory to Galleywood Ward</i>
<i>25th January 2016</i>	<i>17th March 2016</i>	<i>Non-EPUT ward, PICU Potters Bar</i>	<i>Transferred from Galleywood Ward due to challenges with managing risk in acute unit which included self-harm, overdose and alcohol use</i>
<i>17th March 2016</i>	<i>21st June 2017</i>	<i>Christopher Unit, EPUT</i>	<i>Transferred from Potters Bar</i>

21st June 2017	October 2019	Cygnet Hospital	Transferred from Christopher Unit
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22. In addition to the above, from some loose pages of Abbi's notes and diaries, it appears that Abbi was moved to the Lakes in Colchester for a weekend. I am not sure of the exact dates and did not visit Abbi there.
23. The PSII also states that *"When not an inpatient, Abbigail received input from community mental health services"*.
24. Further to October 2019, Abbi was discharged to the community and was seen in outpatient clinic, until she was re-admitted into EPUT on 27 January 2022 and discharged on 14 February 2022 to her supported living accommodation.
25. The next day, on 15 February 2022, she was found with a scarf tied tightly around her neck. She was found at a recreation ground. Resuscitation was attempted but did not succeed. She was pronounced dead on 16 February 2022. Abbi had killed herself.
26. With regards to the question *"How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances, the deceased came by his or her death: (see note (ii))"*, the Record of Inquest states:

*"Abbigail Louise Smith (Abbi) was found on 15 February 2022 at [I/S] Recreation Ground at about 23:25 hours. Resuscitation was unsuccessful and Abbi pronounced deceased at 00:08 hours on 16 February 2022 due to Compression of the Neck caused by Abbi tying a ligature tightly around her neck using a scarf with the intention to end her own life. Abbi had unsuccessfully tried to suspend herself from some branches of bushes nearby. Abbi had a known history Autism and Learning Disability and had spent many years detained under the Mental Health Act and there is **disputed evidence as to her mental health diagnosis**. Abbi had a sustained positive response to Clozapine such that she was discharged to supported living as the attempts to end her life had ceased. Abbi became non-compliant with her medication in September/October 2021, and this was reported to community mental health services. The directions of the consultant psychiatrist, who noted a serious deterioration in her mental health was inevitable, were not followed up and Abbi remained on a medication regime that was known not to work. Abbigail required assessment under the Mental Health Act on 25 and 27 January 2022 when she made attempts to end her life and was sectioned under the Mental Health Act and admitted to hospital. Abbi made numerous attempts to end her life by ligature whilst detained. Abbi was discharged on 14 February 2022 to her supported living accommodation with **no plan to mitigate the known fatal risks** she posed to herself. The conditions required by the community team to facilitate a safe discharge had not been met and no alternative plan had been put in place. Abbi had indicated on 15 February 2022 that she could not give an assurance that she could keep herself safe and wanted to end her life."* (emphasis added)

Abbi's diagnosis

27. Abbi had autism, learning and mental health problems. However, over the years health care professions repeatedly failed spectacularly by addressing her mental health problems in isolation, without tailoring the care to take into account her autism and learning difficulties. Often when I raised with the staff over the years to pay attention on Abbi's autism I was maligned, belittled, sidelined and on one occasion, directly accused me of lying about Abbi's diagnosis.

28. Dr [A] (Consultant Psychiatrist – Forensic Learning Disability and Specialist Autism) prepared an expert psychiatric report (looking into Abbi's care) at the request of Sonia Hayes, HM Area Coroner. In paragraph 10:23.1 of Dr [A]'s report it states:

*"I believe that the **failure to record and clinically consider Abbigail Smith's autism diagnosis**, to make appropriate reasonable adjustments, for staff to be appropriately trained and for her needs to be formulated accordingly, particularly in the context of risk assessment, fundamentally **contributed to the death of Abbigail Smith.**" (Emphasis added)*

29. The Record of Inquest reiterated my long-standing concerns which had been ignored when Abbi was alive, only to surface after her death. In addition to failings which occurred in Abbi's last admission prior to her death, the Record of Inquest also comments on the failings with regards to taking into consideration her Autism (which in my eyes was dangerous practice).

30. The Record of Inquest states:

*"...4. Conclusions of the coroner/jury as to the death: (see notes (i) and (ii):
Suicide: there were a number of failures that contributed to Abbi's death:*

*1. A failure by **all** clinical professionals and **care for, treat and communicate with Abbi as a neurodivergent person with Autism** that **exacerbated** Abbi's presentation and risk of self-harm and suicide. There was **no staff training** for Autism.*

*2. There was a **complete absence and understanding of Care and Treatment Reviews** for those responsible for caring for Abbi and whilst nonstatutory, Abbi was **entitled to these as an Autistic person** who also **had learning difficulties** and would have assisted to get the right professionals together to look to avoid hospital admission.*

3. Abbi's suffered an obvious and predicted deterioration in her mental health when she was not compliant with her Clozapine medication and the failure to follow-up on the community psychiatrist's directions in October 2021 caused her to deteriorate further with no assessment of her capacity that had been advised. Abbi's short-term prescription of diazepam was continued without a required medical review and failed to comply with NICE Guidelines. Abbi was prescribed a treatment medication regime that had been unsuccessful in the past and had not mitigated her ligaturing to attempt to end her life whilst she was detained.

4. Although Abbi had some dialogue about the future on 15 February, she informed the community mental health team that she did not want to go on anymore, had lived her life, could not give any assurances for her safety and was declining help. Advice from the Home Treatment Team was not sought and the community team wanted to step up care, but this had not been put in place and was not the process for a crisis.

*5. There was a gross failure to provide and procure basic medical attention for Abbigail when she was discharged from detention under the Mental Health Act on 14 February 2022 with no plan to mitigate the real and immediate risk Abbi posed to herself with threats, plans and actions to end her life. Abbi had antiligature bedding, and her room stripped of her possessions and **this remained in place prior to her discharge**. There were no up-to-date care plans and risk assessments in place for Abbi to manage this risk or for when she was discharged to the community on 14 February 2022 to mitigate this known significant risk. **Abbi had tied multiple tight ligatures during her 11-day admission and had her usual clothing removed** on 4 February due to her risks, the precise date her clothing was returned was not recorded. On 9 February 2022 community mental health staff required 3 conditions to be met before they would*

support Abbi's discharge, none of which were met on 14 February 2022. This discharge was not safe. The care co-ordinator informed the treating team and responsible clinician that she wanted to attend the ward review on 14 February and had not received a link. The ward review went ahead without the care co-ordinator and no attempt was made to contact her. The responsible clinician was informed by a preceptorship nurse that the Home Treatment Team had refused to accept Abbi as she had a care co-ordinator. This information was known by the treating team to be incorrect the Home Treatment team had agreed to see Abbi on 25 January 2022 and other patients had been assessed and discharged from the Ward with these arrangements previously. This was not checked or challenged, and Abbi was discharged with a real and immediate risk to her life. **Abbi's death was avoidable and contributed to by neglect.**" (emphasis added)

31. With regards to Abbi's diagnosis, which is mentioned above in the Record of Inquest, in my view there would not have been any confusion if when communicating with Abbi they had tailored their approach to take into consideration her Autism and learning difficulties. The fact that healthcare professionals had not done this meant that they were not eliciting correct information from Abbi. They were not speaking the language which Abbi spoke, so how could they then confidently treat her?

32. Dr **A** dealt with this issue in detail in the report. Under the title "Please provide a brief list of Abbigail's mental health diagnoses", parts of which are copied below. The Inquiry will see that Dr **A** queries the diagnoses which Abbi received. The report states:

"...10.2.1. The relevant past psychiatric history for Abbigail Smith is set out within the respective sections of the main body of the report.

10.2.2. Prior to providing a comment as to Abbigail Smith's mental health diagnoses, I would draw attention to the limitations that have occurred due to an absence of information related to her admission to Cygnet Hospital Beckton, both in terms of her presentation that necessitated transfer in June 2017 and – further – the assessments and interventions that were undertaken during that admission that led to changes to the diagnostic formulation, the attribution of a diagnosis of 'Simple Schizophrenia' and that she was commenced on CLOZAPINE.

10.2.3. I note the chronology that sets out Abbigail Smith's initial admission to Child and Adolescent Mental Health Services (Longview and Larkwood Wards) and that 'there were several incidents of self-harm and ligature during this admission. She was considered for **a personality disorder unit**'; she was further transferred to Christopher Unit on September 2013 after turning 18 years (and – thus – being transferred to Adult Mental Health Services), being discharged in January 2014.

10.2.4. I note the further chronology provided by Abbigail Smith's mother, Lisa Wolff, as detailed **within an e-mail to Dr **B** dated 6 February 2022** (replicated within the tabulated summary of Paris records above) that sets out that Abbigail Smith exceeded the threshold on the Autism Diagnostic Observation Schedule (ADOS) (as per Speech and Language therapy report dated 2005), that a repeat ADOS assessment in October 2011 confirmed the diagnosis and that Abbigail Smith additionally presented with significant cognitive deficits that, upon re-assessment, gave a Full Scale IQ = 72, thus placing her marginally outside of the range for a formal diagnosis of a Mild Learning Disability; I interpret the records as concluding that she did not meet the criteria for Community Learning Disability Services, hence her care was overseen by Adult Community Mental Health Services in the period subsequent to her discharge from Cygnet Hospital Beckton.

10.2.5. With regard to the PSII Report, there is reference made to the continued use of the term '**mental retardation**'; this is an outdated, pejorative and stigmatising term that was replaced in

UK terminology by 'learning disabilities'. This was a directive from the Department of Health and was reflected the 'Valuing People' (2001) White Paper and other similar documentation; indeed, research evidence confirms the preference for the use of the term 'learning disabilities' as far back as the 1980s.

10.2.6. I note the referenced diagnosis of '**Simple Schizophrenia**'. However, I have no information as to the basis for this diagnosis (it being made during the admission to Cygnet Hospital Beckton); I further note the presentation of Abbigail Smith following discontinuation of CLOZAPINE and that she presented with a clear degree of distress and self-reported visual and auditory phenomena.

10.2.7. To attribute a diagnosis of F20.6: Simple Schizophrenia, as per ICD-10 (the relevant diagnostic classificatory system at that time) there must be an insidious but progressive development of oddities of conduct, inability to meet the demands of society, and a decline in total performance...

10.2.8. It is relevant to note that Abbigail Smith had experienced a prolonged period of institutionalised care and had further experienced significant and repeated trauma during this time (based upon the records that are available and her self-report). Thus, **I would question the degree to which a definitive diagnosis of Simple Schizophrenia** could be made.

10.2.9. There would be the clear aspects of developmental trauma and the context of her neurodevelopmental disorder (ASD) and cognitive deficits that would also need to be taken into consideration due to the clear symptom overlap; I will further reference the relevance of Abbigail Smith's history of in-patient trauma within my responses related to her care and treatment during her most recent inpatient admission to the Linden Centre between January – February 2022.

10.2.10. I note the diagnosis of **Emotionally Unstable Personality Disorder (EUPD)** that is, based upon the general practice summary, recorded in April 2019 and that, as per Section 8.10.27, a diagnosis of EUPD was attributed to Abbigail Smith in October 2015; **there is no evidence of any validated assessment for Disorders of Adult Personality within the provided records or any evidence that consideration was given to her existing diagnoses of Autism Spectrum Disorder (ASD) and her borderline Learning Disability when a diagnosis of a Disorder of Adult Personality was being considered.**

10.2.11. With regard to diagnoses of ASD and Emotionally Unstable Personality Disorder, a diagnosis of any disorder of Adult Personality is predicated upon the presence or a range of cognitions, emotions, and behaviours that have been present throughout childhood and adolescence and are applicable and observable across a number of different situations. In the case of Abbigail Smith, that she had remained within institutional care, i.e. hospital settings, throughout the entirety of her adolescence and adult life to the point of the EUPD being applied, arguably precludes a clear demonstration that her behaviours were present across a range of settings and were not merely a result of her situation, circumstances and a reflection of the failure of services to address needs associated with her ASD. **It is also notable that she was placed within a range of services that were primarily geared to meeting the needs of patients with mental illness or Disorders of Adult Personality and – thus – it could be argued that she had not been afforded relevant care and support within a service that fundamentally addressed and understood the manifestation of her autism;** I would further note the relevance of the referral to the National Autism Unit in this regard.

10.2.12. I would also note the evidence that confirms that Abbigail Smith **has 'learnt'** a broad range of behaviours and has manifested a range of coping strategies that reflect both a response to processes within inpatient settings and are, arguably, a further manifestation of a

narrowed repertoire of responses and strategies as a result of significant limitations upon her freedom and her inability to apply more sophisticated and arguably pro social strategies; I would again view this as being reflective of her history, would note the references to her having experienced the death of peers by suicide and would also draw attention to the **concept of autistic monotropism** that posits that autistic individuals tend to focus intensely on a narrow range of interests or activities, often at the expense of broader, more generalized attention distribution, whilst referred to and commonly referenced as 'special interests' or 'obsessions'.

10.2.13. Monotropism can also lead to an intense focus on negative thoughts or emotions such that, when faced with distressing situations, this cognitive style can cause individuals to ruminate on negative experiences or feelings, making it difficult to shift attention away from these harmful thoughts. This rumination can then exacerbate feelings of hopelessness and despair, contributing to suicidal ideation; monotropism can also result in social difficulties as autistic individuals may struggle to engage in social interactions that do not align with their interests which in turn can lead to feelings of isolation and loneliness which are significant risk factors for suicidal ideation (**with autistic people being 8 – 9 times more likely to present with suicidal ideation than the general population**). The lack of social support and understanding from others can intensify these feelings, making it harder for individuals to seek help or share their struggles; monotropism can also compound issues related to cognitive and sensory processing (and **Abbigail Smith's IQ** should be noted as a relevant factor) as, when overwhelmed by external stimuli or life changes, the resulting stress can contribute to mental health issues, to include anxiety and depression, and the inability to effectively switch attention or adapt to new situations can again make these experiences particularly distressing, further increasing the risk of suicidal thoughts and acts.

10.2.14. Accordingly, I would **not be confident to attribute a diagnosis of a Disorder of Adult Personality in any individual with a pre-existing diagnosis of an ASD without robust and rigorous assessment by a specialist service (and I note no evidence of such an assessment within this case)**; it should be noted that there is an increasing awareness of the **misdiagnosis of EUPD in autistic females** (both those with a confirmed diagnosis and those whose autism diagnosis has been missed), with Tier 4 Personality Disorder services anecdotally suggesting that at least a third of referrals of those with EUPD either have a co-occurring diagnosis of an ASD, or a primary diagnosis of an ASD, and that the diagnosis of a Disorder of Adult Personality is wholly incorrect.

10.2.15. Overall, there is clear evidence that Abbigail Smith has **undergone repeated validated assessments that have confirmed the diagnosis of an ASD**.

10.2.16. There is further clear evidence that Abbigail Smith has a level of cognitive and adaptive functioning within the borderline range and that, at times of distress, I would anticipate that her effective level of functioning and cognitive processing would have been akin to someone with a Mild Learning Disability; this does not equate to her requiring specialist community learning disability services but **the evidence of communication and processing deficits would need to have been considered in the assessment and formulation of need and relevant risk assessments and support plans**.

10.2.17. I do not see clear evidence that Abbigail Smith has an underlying psychotic illness and would point again to the confounding factors that would provide an alternative explanation for her cognitive and adaptive decline during prolonged institutionalisation.

10.2.18. I note that Abbigail Smith experienced a range of transient symptoms at points of significant distress and following the withdrawal of antipsychotic medication and would similarly

note the presentation of transient psychosis in autistic people who experience significant difficulties with processing, often in the context of emotional dysregulation secondary to life events and other stressors.

10.2.19. I would further note again that Abbigail Smith reported a significant **history of repeated trauma** and that a presentation with post-traumatic stress disorder (**PTSD**) or complex post-traumatic stress disorder (**C-PTSD**) is often accompanied **by transient psychotic phenomena** and further feelings of detachment in the context of an overall negative self-concept (self-identity) with low self-esteem (often feeling worthless, inadequate or inherently flawed stemming from prolonged exposure to trauma which undermines a sense of self-worth) and further self-blame or guilt that is objectively seen as irrational and that leads to pervasive guilt and a negative self-view; thus, with accompanying emotional dysregulation as a 'fight or flight' response in the context of hypervigilance, **this would provide an additional alternative formulation to those symptoms that have been attributed to EUPD and Simple Schizophrenia.**

10.2.20. **On the available evidence, I cannot make a diagnosis of PTSD or C-PTSD.** However, it is my opinion that **there is a clear validity to these as differential diagnosis** and that there has been **no evidence of consideration of Abbigail Smith's overall presentation and history in the development of a diagnostic formulation**; I will make further comment as to the relevance of such a formulation within the following responses related to her care and treatment and discharge planning." (emphasis added)

33. I would like to add, as Abbi's mother, and next of kin, that no one ever clearly communicated to me the diagnosis of schizophrenia and Emotionally Unstable Personality Disorder (EUPD).

34. Dr **A** mentions above "...10.2.4 I note the further chronology provided by Abbigail Smith's mother, Lisa Wolff, as detailed within an e-mail to Dr **B** dated 6 February 2022 (replicated within the tabulated summary of Paris records above) that sets out that Abbigail Smith exceeded the threshold on the Autism Diagnostic Observation Schedule (ADOS) (as per Speech and Language therapy report dated 2005), that a repeat ADOS assessment in October 2011 confirmed the diagnosis and that Abbigail Smith additionally presented with significant cognitive deficits that, upon re-assessment, gave a Full Scale IQ = 72, thus placing her marginally outside of the range for a formal diagnosis of a Mild Learning Disability..."

35. Dr **B** is a clinician at EPUT. The following is the email which I sent to this doctor on 6.2.22 – was this information appropriately considered? – if not, why not? My email stated:

"Dear Doctor **B**

Please find attached some of the documents we spoke about on Saturday 5th Feb with regards to my daughter Abbigail Smith, currently a patient at The Linden Centre. Thank you for taking the time to contact me and to ask and listen to my concerns. My journey with Abbi has been a difficult one, as I am sure you will be able to tell from the snapshot of assessment information which I have enclosed to try and present you with a picture of the levels of complexities with which Abbi has always presented.

Speech and Language report 2005

Page 3 describes Abbi as "scoring above threshold on the ADOS scale for autism and needing a more protected environment with a high degree of specialist support and expertise in autism".

Consultant Child Psychiatrist Report May 2006

Describes her self harming behaviour and lists her problems and diagnoses to include "Learning Difficulties". It also states she has a "complex neurodevelopmental disorder" and that she has a "subtle presentation". It further makes reference to her speech and language issues being linked to central processing problems and the need to "break down verbal instructions with repetition". There is also mention of her having "little awareness of danger and being socially naïve and easily led". The last page talks about her needing a "high level of individual support and for staff to be aware of her history of low mood and self harming behaviour".

Consultant Child Psychiatrist Report 2006

Again this letter lists Abbi's diagnoses but describe her low mood and mentions self harm. The Dr further states that she feels Abbi is a "vulnerable child" who "is at high risk of developing depression if not adequately supported."

Children's Initial Assessment SS 2007

Gives you an overview of Abbi's presentation and some background, as documented by the Children with Disabilities Social Worker.

Neurodevelopmental and Cognitive Assessment 2011

This is the document where Essex LA reassessed Abbi, further to her original diagnosis by Stockport. They completed both a Wechsler (WISC) assessment and an ADOS.

The WISC showed that Abbi scored extremely low for her verbal comprehension placing her on the 0.5 centile and extremely low for her full scale IQ placing her on the 2nd centile.

The ADOS was conducted and the result is on page 2 under the addendum 12th Oct '11. It states that Abbi "does meet the criteria for Autistic Spectrum Disorder".

Page 11 gives a full breakdown of her raw scores for the WISC.

OT evaluation of ADL ability 2014

On page 2 the Occupational Therapist states "the results of the AMPS observation fail to support the occupational therapists judgement that Ms Smith needs assistance to live in the community with regards to functional ability and therefore outside factors likely are resulting in Ms Smith's need for assistance in the community".

The OT also states that "Ms Smith's ADL motor ability measure is closer to the AMPSM motor cut off measure suggesting the potential for problems when performing chosen, familiar and life relevant ADL tasks and that future OT services may be indicated to enhance and or prevent further decline of Ms Smith's ADL task performance.

OT Discharge Report 2015

The first page makes mention of Abbi's dislike for changes to routine and that she seeks self stimulating and sensory seeking behaviours. "Predictable surroundings and activities are a more comfortable environment for Abbi and she is reluctant to entertain variations to this unless it is with the support of her mum."

On page 2 the OT notes "however, it is my professional opinion that Abbigail does require assistance to live independently and she currently receives a great deal of support from her mum. Should Abbi live in an environment without the support of her mum in the future her level of support needs would very likely increase. This is mainly in relation to managing her anxiety, maintaining her mental health and the risks to herself and managing relationships with others.

I did not want to send all of Abbi's assessments, and thought it best to send you those which give you insight into the complexities of her presentation and the comorbidities she tries to manage on a daily basis. Simply "treating" her mental health and discharging her back into the community with no support, will result in failed discharges, with Abbi continuing to deteriorate and becoming further institutionalised.

I have been maligned by many clinicians over the years for saying Abbi has autism and some have accused me of lying; none have ever bothered to read the documentation to try and find out more about her or understand her. My dearest wish is that my daughter is happy within the sphere of her own life, and find a reason to be hopeful and a reason to smile when she wakes. I simply want her to feel happy and fulfilled in however she chooses to live her life. Thank you for attempting to break the cycle and trying see her as an individual and not a diagnosis.

Many years ago I went to see a unit that I hoped would be more suitable for Abbi than the St Aubyn Centre. They are a psychiatric hospital but specialise in treating those with autistic spectrum disorders and it occurred me to that it might be beneficial to reach out to them to see how they facilitate discharges into the community and what kind of support their patients need in order to to mitigate the self injurious behaviour and enjoy a safe and sustained discharge?

I will leave that to your best clinical decision:

[hayes-grove-rehabilitation-and-recovery-service.pdf \(prioritygroup.com\)](#)..."

(emphasis added)

Abbi's admissions

36. For the Inquest, Dr [C] provided a summary of the various admissions in a statement dated 7.5.24. I have used this to assist with providing the Inquiry background information.
37. Dr [C]'s statement of 7.5.24 states "This factual matrix is provided on behalf of Essex Partnership University NHS Foundation Trust ("The Trust") to summarise Miss Smith's previous admissions from 2012 to 2019".
38. In addition, Abbi kept various diaries and notebooks, recording her experiences and feelings for a significant period of her life which I have also reproduced in part. I have only included some of Abbi's diary entries due to their volume, **but request that the Inquiry consider all of Abbi's diaries** in their entirety for the obvious reason that they give valuable insight into Abbi's care.

Longview and Larkwood wards (CAHMS) of the St Aubyn centre

39. From memory, Abbi was assessed when she was about 16 / 17 years old for her admission into the St Aubyn Centre.
40. There are a number of entries in Abbi's diary prior to, and from around the time of, Abbi's admission to the St Aubyn Centre. Some extracts from Abbi's white diary with owls state the following:

23.08.2011

"...had to go to the police station because an insident happend to me ... this man he was 60 years old and i am 16 and he tryed to kiss me in the sauna i pushed him off ... i was so scared..."

31.05.2012

"...i was very upset but i dont know why ... i took this thing in the toilet with me and i strangled myself with it because i wanted to die so [I/S] unlocked the door somehow and took it off my neck... i just wanted to kill myself :(..."

01.06.2012

"...i was still very upset but i was happy about going to harlow ... [I/S] said Abbs your not going to harlow today and I was so upset [I/S] came in the moter therapy room and lied down on me and [I/S] said I'm sorry Abbi and i said please let me go and i just cryed and cryed...when [I/S] got off me i tried to run out of the room so I coul'd go to harlow but i got held down but i had the waighted blanket and my vibrating pillow but I cryed for ages... I really wanted to go if i needed the toilet i woul'd need someone to go with me because i would hurt myself...then i said to [I/S] i need the toilet and she said come on then so when we were near the toilets i tried to run off because i still really wanted to go to harlow i was going to walk there...[I/S]locked the doors so i couldn't get out but I got out i unlocked the door and i ran down stairs and [I/S] stopped me...i said i think of dying all the time and so I got sent to a mental hospital The women that came to see me was psychologist she is from the st auybny centre in colchester and she became my phycoligist..."

41. Dr [C]'s statement states that this first **inpatient period** was from **22 July 2012 – 30 January 2014**:

"...3. Miss Smith was admitted on the 22 July 2012 to Longview. This is a 15 bed Generic Adolescent Unit that provides assessment and treatment for young people between the age of 13 and 18.

4. Miss Smith - 17-year-old then, was initially admitted, to Longview Child & Adolescent Unit on 22nd July 2012. She was admitted to the A&E Department following an attempted overdose and was assessed by the Child & Adolescent Mental Health Service (CAMHS) Crisis Outreach team. She had a history of self-harming by cutting, banging her head and putting ligatures around her neck for many years. It had been reported to have increased in frequency and intensity over the last two years. She had also received input from the CAMHS Crisis Outreach team in the past following self-harm incidents.

*5. On 16th October 2012 Miss Smith insisted on leaving the unit (Longview) and refused to stay on the unit. Because of the increasing self-harming behaviours and being adamant, that she wanted to kill herself, Miss Smith was assessed under the Mental Health Act (MHA), resulting in Miss Smith being placed on Section 3 of the MHA. Due to increasing risks and needing a more secure and contained environment to keep Miss Smith safe, she was transferred to Larkwood Unit on 13th February 2013. Immediately after her transfer Miss Smith made a serious attempt to put a ligature around her neck. She had also been seriously banging her head causing several injuries to herself requiring attendance and review at the local General Hospital. She had also required the use of **protective head gear** to prevent head injuries.*

6. On Larkwood Unit, Miss Smith continued to self-harm repeatedly, refused food and drinks and had appeared distressed, expressing self-harm and suicidal thoughts with intent, requiring restraining and de-escalation. Whilst at Larkwood Unit, Miss Smith made disclosure of being raped by a support worker in the past, the sharing of which had understandably been very difficult and distressing for her and resulted in increased selfharming behaviour. Whilst in Larkwood Unit, Miss Smith often appeared distressed and expressed a wish to die; however, there had been times when she said "everything was fine" and denied any suicidal thoughts (despite evidence to the contrary) and expressed a wish to be discharged from hospital.

7. During her stay in Larkwood Unit, Miss Smith was referred to the Maudsley & Bethlem Hospital for specialist treatment. She was assessed by Dr [I/S] Clinical Psychologist – Group Analyst in August 2013 and Miss Smith was placed on a waiting list to be transferred to the Maudsley & Bethlem Hospital.

8. As Miss Smith had reached the age of 18, she was referred to the Adult Service by the medical team at Larkwood Unit. On 24th September 2013, Miss Smith was transferred to the Christopher Unit, The Linden Centre.

Medications during this admission:

9. When Miss Smith was admitted to Longview, she was on Fluoxetine 60mg once daily but as she didn't find it helpful and as clinically effective, Fluoxetine was gradually reduced and stopped and was commenced on Sertraline. The dose of Sertraline was gradually increased to 200mg od.

10. She was started on Melatonin to help her to sleep which was stopped eventually and was started on Zopiclone.

11. Miss Smith when transferred to Larkwood Unit, was on Sertraline 200mg bd and Zopiclone 7.5mg nocte.

12. Miss Smith was commenced on Aripiprazole starting with 5mg once daily initially, increased upto 20mg once daily in March 2013 in order to augment the effect of the antidepressant.

13. As Miss Smith continued to present as low in her mood, there was a switchover from Sertraline to Venlafaxine in May 2013. The dose of Venlafaxine was gradually increased up to 150mg bd in July 2013.

14. In terms of as required medications Miss Smith required the use of Lorazepam orally, Clonazepam im, Aripiprazole oral as well as IM when in a very distressed state and for rapid tranquilisation. She has also required the use of Ibuprofen and Paracetamol to reduce the swelling on her forehead following head banging.

15. At the time of discharge from Larkwood Unit, Miss Smith was on Aripiprazole 20mg mane, Venlafaxine 150mg bd, Zopiclone 3.75mg nocte, Microgynon 30 oral contraceptive pill.

Final diagnosis:

- F32.2 severe depressive episode secondary to trauma she has experienced in the past.
- F70 mild learning disability
- F84 pervasive developmental disorder / autistic spectrum disorder

Discharge/transfer medication:

- Venlafaxine 150mg bd
- Aripiprazole 20mg od
- Zopiclone 3.75mg nocte
- Contraceptive pill Microgynon 30
- Lorazepam up to 2mg per day oral prn... (emphasis added)

42. I would like to make the following comments regarding some of the above entries from Dr [C]'s statement:

- a) With regards to paragraph 4, it is my recollection that Abbi ligatured and head banged very rarely, this increased in severity post admission to MH services.
 - b) With regards to paragraph 6, and “being raped by a support worker in the past”, this information was never shared with me and I am only finding out about it whilst preparing this Rule 9 statement, I am aware that later in a different admission (post discharge from the St Aubyn Centre) that Abbi attested to an ex LSA [redacted] from her school telling her that he was going to “bust her out” and it is alleged he gave her cocaine. I am unaware if it is alleged, he sexually assaulted her. To my memory this was 2016.
 - c) With regards to paragraph 7, and referral to Maudsley, this admission to Maudsley never took place. I was informed that the unit had closed down.
 - d) With regards to paragraph 8, and being transferred to the Linden Centre: right from admission in to St Aubyn Centre, I had been reassured Abbi was not an appropriate person for admission into the Linden Centre due to her vulnerability.
 - e) With regards to the final diagnosis of “F70 mild learning disability”, they constantly denied Abbi had LD and they informed me she had been assessed by the CLDT whilst in the St Aubyn Centre and did not meet the criteria for diagnosis.
 - f) With regards to the final diagnosis of “F84 pervasive developmental disorder / autistic spectrum disorder”, this was despite them telling me time and time again that Abbi did not have autism. Abbi actually shared with me that the St Aubyn Centre staff had told her she did not have autism and I think this confused her. During her subsequent admission to the Christopher Unit (Linden Centre), in the first CPA, I make note later in this document that a clinician remarked that the notes from the St Aubyn Centre made no reference to Abbi’s autism whatsoever. This was in reply to Dr [redacted] D (the consultant) asking me if I was aware my daughter had Autism. I recall the staff from [redacted] her school who were present, remarked that they needed to go and tell the headteacher that Abbi now did have autism, according to this consultant, when the St Aubyn Centre had told them she did not have autism.
43. On first impressions, the St Aubyn Centre appeared to be a well-equipped, purpose-built unit. After walking through three security doors, you were in the main hallway, which was large and airy, and at each end of the hallway was one of the wards - Longview was at one end and Larkwood was at the other end. Larkwood was the equivalent of the PICU. I was never given the opportunity to see inside the wards and only ever able to see the family rooms, the hallway, the meeting room and once one of the pods. There were games in the hallway such as snooker and table tennis although there was nothing in the family rooms except for a couch. Overall, I believe that the unit was a suitable environment in which to provide inpatient mental health care, if appropriately delivered by qualified and caring staff – which in my view did not happen with Abbi.
44. I believe this unit would support matters such as nutrition, physical health and hygiene. However, I recall Abbi telling me numerous times that there were male members of staff on her 1:1 observations who would sometimes use the toilet in her room without asking and not close the door, so that she could see what they were doing. This obviously greatly concerned me.
45. This admission was incredibly damaging, and Abbi never recovered from her admission here; it simply set her up for a lifetime of institutionalisation. There was a school, and Abbi was required to attend. I never saw this school and have no idea what curriculum they tried to deliver to her. At other times there were activities held internally and externally - basically, used as bribery to try and ensure obedience. Access to these activities were removed if Abbi self-harmed, even if her self-harm was

as a result of the staff's poor treatment, or of the staff breaking a promise to her. These activities were available to patients and could be engaging and meaningful. Abbi had access to outside space, although sometimes this was limited - I only remember one occasion when Abbi was only allowed into their quadrangle during a six-month period.

46. I do not believe that patients or relatives were respected at this centre, and I do not believe that the privacy and dignity of the children who are unfortunate enough to be sent here is respected. The following are examples of horrific care which Abbi /others were subjected to **(there is more detail / instances of what I would term as "abuse" in this centre later in this statement)**:

- Abbi documenting that she was held down in a chair and force fed.
- Abbi sharing that she had seen a patient being dragged by her hair out of the shower half naked, down a corridor by a member of staff.
- Abbi being continuously held down and tranquillized, to the point where staff were commenting *"get off her guys, all she needs is a hug!"*.
- My witnessing, through a window in the section 136 room, of what appeared to be inappropriate restraint of a child.
- When I raised my concerns with the modern matron of the unit, I was asked *"who do you think people will believe, us professionals or these children with mental health problems"*.
- Staff promising Abbi that she could attend her grandmother's funeral right up until the morning she was due to go and then telling her last minute that they did not have staff to accompany her. This resulted in severe self-harm, but once again the ward accepted no recognition that their actions caused this.
- The staff not allowing Abbi to speak to her sister – informing her that Abbi was asleep, when she was not. Similarly, the staff not allowing Abbi and I to speak to each other, unless they listened in to our conversations – the staff never provided a reason as to why they were doing this.
- Abbi knew some of the children that subsequently died on this unit. I believe this affected her greatly.
- The staff trying to hide from me that Abbi had head banged so badly that her forehead protruded further than her nose – when I saw Abbi, she was so tranquilised that in order for her to come to me, two staff had to drag her by her shoulders.
- Abbi disclosing to me that staff would use her toilet in her room, in full view of her, without closing the door.
- Abbi telling me numerous times that staff would sleep on their one-to-one observations of her.

47. I had very grave concerns about Abbi being on Larkwood Ward. Horrific things happened to her, she witnessed horrific things and shared them with me and when I tried to complain, I was not listened to. If I recall correctly, I engaged the support of Autism Anglia to put forward the complaint, which was sent to Andrew Geldard – I have discussed his response below. I also complained to CQC and was led to believe that an investigation was conducted and I heard on the grapevine that two people had been moved to alternative establishments because of the complaint. I believe with

all my heart that this unit caused Abbi severe PTSD, from which she never recovered, I believe I probably have PTSD from her time on this unit and I think about some other things that were done and said to both her and me, on a daily basis. As far as I am aware Abbi also made numerous complaints, including a written complaint which is enclosed below. Abbi said that she shared this document with her care coordinator involved in her care, and once they had read it, they had offered to support her to take the complaint to the police but Abbi took her life before this could be completed. This admission haunted her right up until her death. She would always talk to me about the horrific things that happened to her and that she witnessed there. She would discuss these with me on the phone and in person.

48. Abbi's complaint is entitled "Larkwood and what it was like for me"; she wrote this letter on approximately 21 December 2021. It states the following:

"Larkwood and what it was like for me"

Ok where do I begin this is hard to write but I feel like people need to know what happened when I was 16 I got admitted to Longview and had no issues with it but when I was 17 they couldn't keep me safe so I went to lark wood which is a secure ward and that was the worst mistake ever as I got mistreated by some of the staff it was torture the ward manager was [F] and she was horrid she said it's meds time I said to her I'll take them later and she didn't like the fact I said that so she got loads of staff out of the office and they dragged me to my room threw me to the floor and [F] sat on my back and I got injected another thing that [F] did to me I had to wear a big red boxing helmet and I had my family come to visit and I said can I take it off while they visit me she then said no so I had to cancel my visit as I didn't want my mum to see me with a helmet on my head and one time I was in bed The staff made me sleep with the helmet on and if I tried to take it off they would restrain me and put it back on my head and when I woke up I said I'm not leaving my room for people to see me with the helmet on and [F] said you are so she grabbed my wrist and dragged me off my bed to the point where in the morning I had a bruise on my wrist I was so young at the time I should of taken a picture of the bruise [F] had given me but staff hid the fact that she bruised my wrist and wouldn't allow me to call my mum and tell her what she did my gran died when I was in larkwood and I said to [F] can I go to her funeral and she just said your not going anywhere at this point I was grieving for my gran and I couldn't even say my goodbyes [F] is heartless. The next issue I had was with a staff member called [H] he loved the power of hurting people he restrained me put me in locks and I was screaming and crying in pain because of the amount of pressure he was putting on my hands I screamed and said [H] your hurting me and he put the locks on even harder it's like he got enjoyment over hurting me and when my mum would ring the office [H] would answer and would make up lies and say I'm sleeping when I wasn't I was wide awake it got even worse there was a staff member called [J] and she restrained me and in the process kneed me in the stomach she said you brought it on yourself and one of my close friends not going to say her name but [J] pushed her head against the wall and twisted her arm to the point where this person sat on the sofa crying she was in so much pain she couldn't move her arm she had to go to A&E and have a sling put on her arm and yet again staff covered it up all the staff in larkwood they loved the power it got to there heads it was meant to be a safe place for people to get better but it wasn't it was a living nightmare another issue I had was with a staff member called [I] there was a patient who found a snail shell in his veg and I said to [I] I'm not eating that and that was it then she said you are eating it so she called loads of staff out of the office and I was tucked in to the table I couldn't move staff were holding my hands to the table while another staff member held my head back and [I] shoved food down my throat and held my nose to give me a drink it was torture I wouldn't wish this experience on any one it is something that has scarred me for life staff in larkwood had no clue about mental health and should not have been working there [K] was the ward manager for Longview and she was so nice [K] would always come to larkwood to check on me and [F] came to work when she felt like it [K] was so caring I remember when loads of staff restrained me and yet again [F] was there I had so

many staff holding me down but [K] came in and she kneeled beside me and stroked my head and she said come on guys get off her now all she needs is a hug and the staff eventually got off me and [K] gave me a hug I didn't deserve to be mistreated and tortured I thought it was meant to help people get better and recover but instead this has left me broken not being able to ring my mum and tell her about the bruise [F] had caused and what really went on behind closed doors a staff member let a patient out on leave didn't check where she would be going and I know the whole story of her death and she was only 17 her death could of been prevented if this staff member didn't let her out I had other problems like when I was on level 3s staff (men) would be on there phones and I couldn't sleep knowing that there on there phones as they could be doing anything like taking pictures of me asleep or videoing me and staff again (men) would be on my level 3 obs and they would sleep and snore really loudly I said to him I can't sleep your snoring he then said to me I wasn't asleep when he was and I also had an issue I was in my room and a staff was on my level 3 obs and he said I'm just going to use your toilet which was in my room I was sat on my bed and he used my toilet and left the door wide open I told staff but no further action was taken another member of staff asked me to go to Africa with him when I get discharged I told [K] he then got moved to Longview another time I had home leave for the first time in months so I was so excited I was going home I went with two members of staff my leave went really well had no issues but in my ward round I asked for home leave again without staff and they granted it me but it was with two staff again I felt like I was getting no where so I got back to the ward and banged my head and it got handed over to the staff that abbi banged her head because of her going home this was not the case at all what ever you say to the staff it gets twisted round another time my phone calls got recorded have no idea why but I had to have it on loud speaker for staff to listen in my conversations with my mum it was horrible I couldn't say anything to my mum because they were listening and I would sometimes sit in the corner and cry and [I/S] would just shout at me and tell me to STOP CRYING this made it worse and when I spent time with my mum and watched a film a staff member would just walk in and sit down for no reason it was mostly [I/S] and [J] who would walk in I wasn't even on level 3 s they just walked in I just wanted it to be me and mum and when it was my 18th birthday it was horrible as I had a staff member on my level 3 obs Which was [I/S] and he sat in the blue pod with me when my mum and sister came to visit me he didn't give me any space at all or It would be community meetings and the phycologist would say to me why are you sat like that and I was sitting normally so I really don't get it and one time I sat outside and there was a black tent you could sit in and I head-banged and cried because I was distressed [I] then grabbed my legs dragged me out of the tent pulled her alarm and about 10 staff came and held my head down to the point where they were hurting me and had locks on my hands no one should be treated like that I don't want anyone else to go through this I try and forget but can't they have completely broken me"

49. In addition, the below is a copy of Abbi's concerns she submitted to CQC about her stay in the St Aubyn Centre:

"Do you have concerns about the service: Yes

Even though I hadn't hurt myself for a long time - staff promised I could go to my grans funeral and then they refused to let me go. I cried and went to the ward manager of Larkwood ward [F] and said "can I go to my grans funeral" - she just laughed in my face and I wasn't allowed to go.

The psychologist from the st aubyn centre **Psychologist G** visited me after I was transferred to an adult unit - he said to me "your parents don't like me very much do they" he also tried accuse [I/S] of abusing me - even though I know he didn't. [G] also told me that I was pretending to be better and that I would only last 2 weeks before I hurt myself - he told the staff this on my new unit but I didn't hurt myself again!

When **F** restrained me - she sat on my back and my legs .

H (nurse) twists your hands so that it really hurt - other staff didn't do this.

A bank staff (man) was doing my obs - he asked if he could use my toilet in my room, I said no but he ignored me and used it anyway, he tried to shut the bathroom door but it bounced open again I looked away quickly so I didn't see him weeing but when I turned round I saw him leave the bathroom without washing his hands.

If I was upset when **[I/S]** (nurse) was on duty she would shout and scream at me and tell me to stop it.

J (nurse) liked to restrain patients on her own without calling for help. She restrained a friend of mine and my friend hurt her head and her arm because **J** pushed her head into the wall and twisted her arm. My friend was crying on the couch afterwards and couldn't move her arm. She was taken away in an ambulance and had to have a bandage on her arm. I tried to ask staff if my friend was ok but they said that staff were not allowed to talk about what had happened but **J** was off for a couple of days, but she came back.

A bank member of staff (man) asked me to go to Africa with him and it scared me. I had to make a statement with **[I/S]** (the ot) but the man just went to work on the other ward (Longview). There were lots of bank staff who were supposed to be doing my obs while I was asleep (someone was supposed to be with me all day and all night) but they fell asleep and snored so I couldn't sleep.

Staff would use their telephones whilst they were on my obs during night time (mostly men).

I (nurse) would force me to eat by holding my nose and shoving the food into my mouth - even if I had already eaten some food .

I didn't want to have my tablets one morning and asked **F** if I had to have them, she dragged me down the corridor to my room and injected me in my bum.

once I got upset while I was in my room at night - the bank staff man was asleep instead of doing my obs so I hurt myself.

A regular member of staff **[I/S]** played on her Nintendo DSI while doing my obs at night but I was not allowed my DSI because I was told it had a camera.

What was good about the service:

There were some nice people there who helped me to stay strong but they were other patients. Longview was better than Larkwood as the staff were nicer.

I did get on with some staff who were nice to me - **K** / **and three others**
I enjoyed the trampolining when I was allowed out.

Other comments:

I was at the St Aubyn centre for fifteen months, they didn't help me at all, they made me much worse and there was a long long time where they didn't let me out at all - not even for 10 mins in the grounds.

When I was transferred to adult services - they saw me differently and stopped my meds straight away and I started to get better straight away. They allowed me to have ground leave and then allowed me to go home, I got better and better - it only took nine weeks for me to get lots of home leave over Christmas. I went home on the 24th dec and had a nice Christmas, I was due back at the unit on the 2nd January 2014 and was allowed home again the next day and got to stay at home until my discharge cpa on the 24th January 2014. I am now completely discharged and at home, happy, but I want everyone to know what I went through at the St Aubyn Centre and I worry about my friends that are still there."

Complaint correspondence

50. A more thorough account of what happened will be in the complaint I submitted to the Trust, dated 30 May 2013. As I wrote this nearer the time that I had concerns with regards to Abbi's care, I would like the Inquiry to consider this correspondence in full. Even at that stage I was writing to the Trust, stating that Abbi was diagnosed with Autism / Speech & Language Processing Disorder / Learning Disability / Dyspraxia / Social Anxiety Disorder. It covered matters such as that the care received and environment at the St Aubyn Centre exacerbated her condition, and specific incidences of concern. In addition, it stated that *"... her mental health cannot be addressed without consideration given to the fact that she has Autism..."*.
51. In the addendum to my complaint letter, I explain what The National Autistic Society – Self Injurious Behaviour booklet states, with regards to structure and routine, and give example of activities that may help those with Autism.
52. I received a response from Andrew Geldard, which I consider to be inadequate – opening with *"...[a]s you appreciate the concerns you raised are rather complex..."*. Mr Geldard's letter also stated that *"...[t]he decision by Abbigail that she does not wish for detailed information to be shared with her parents has formed the contents of this letter..."* explaining that only limited information regarding my complaint and concerns could be discussed with me until the Trust received a formal letter from Abbi's advocate.
53. In summary, Mr Geldard's letter dated 31 July 2013 addressed my complaint as 'a difference in opinion' between myself and those caring for Abbi. Mr Geldard's response states:
- "...At the centre of Abbigail's care and treatment appears to be a difference of opinion between yourself and your partner and the professionals caring for Abbigail about the cause of Abbigail's present difficulties and the most appropriate care that Abbigail needs at this time I understand that as a family you place considerable emphasis on Abbigail's learning difficulties and Autism as the primary difficulty and report that Abbigail has having a moderate learning disability..."*
54. Mr Geldard explained that they viewed Abbi 'more able' although lacking in confidence due to severe depressions stemming from sexual abuse trauma, whereas I was placing emphasis on her learning difficulties and Autism as the primary challenges that were not being accounted for. He concludes that if I would like to discuss any part of the letter further, then I should contact [I/S] (Abbi's Consultant Psychiatrist) in the first instance. How is this appropriate, given that he is directing me to one of the people that I had complained about on Larkwood ward?
55. I hope that the Inquiry will consider my complaint correspondence in full, which includes my concerns regarding Abbi's care in depth along with detailed accounts of my communications with the ward staff, as well as Mr Geldard's complete responding letter.
56. For the purposes of my statement, I will mention just some of the many instances that stick out to me:

- A male member of staff (bank) watched whilst Abbi attempted to self-ligature with her bra. They did not sound the alarm until it was nearly too late. I do not know if he (the staff) was enjoying watching her without her bra or had fallen asleep during his observations. I only found out about this detail during a CPA, accidentally, at which point all the team present started looking round to each other very uneasily and said that this member of staff would 'not be back'.
- Abbi telling me that a male member of staff had asked her to go to his country with her when she was discharged.
- Abbi telling me that one of the members of staff [J] had restrained a female patient inappropriately, to the point where her arm had been broken. Abbi also told me that all of the young people had been gathered together and told not to talk about this to anyone. After her discharge, and in fact years later, Abbi would also tell me that it was [J] amongst others, who really enjoyed the power and hurting people.
- I was informed by staff that all of my phone calls to Abbi would be recorded in future and that staff would have to be present during my visits with Abbi. They told me that this was at the say so of the head of Essex Safeguarding lead, but to this day I do not know why they reported me. I would like the Inquiry to find out why – I need to understand why and be given the opportunity to explain if possible, as the guilt that I may have done something wrong, or the fact that I had been wrongly accused of something, still haunts me.
- I remember arguing with the clinical psychologist, [Psychologist G], because he told me that Abbi would not see me i.e. that she refused to see me. I recall becoming very distressed at this, and said that unless my daughter told me herself, I would not be leaving the ward. Hours later, Abbi was dragged out of the ward by two female members of staff - they each had one of Abbi's arms around their necks as Abbi was so medicated that she could not walk for herself. In addition she had been head banging so badly that her forehead was swollen to the point where it extended further than her nose. Abbi had come along to have a brief conversation with me (and for me to give her the "Wanted" annual she had asked for). She actually seemed very pleased to see me, but I had encouraged her to not spend too long with me and to return to her room because she needed the rest. Once I reached my the car I broke down and it took me a good half an hour to be calm enough to attempt the drive home. During this drive home I received a call from her key worker, [I/S] who had informed me that he had just come on duty and he was taking Abbi for a head scan at the hospital . I turned the car round and drove to Colchester General Hospital. I met both the team and Abbi. Whilst there, Abbi behaved appropriately and engaged with me - although she ignored the other three or four staff that were present from the unit. She waited for the scan. I seem to remember being told that one of her pupils was blown, but that the staff weren't worried because it wasn't both? I also remember telling a nurse how worried I was about Abbi's safety in this unit and despite this the staff explaining to me that they still had to discharge her back to the care of the St Aubyn Centre. I remember waving to Abbi after the taxi drove away with her in the back seat and she turned around waving at me. I also recall the telephone call from the mental health unit hours later to tell me that as soon as Abbi had walked through the doors of the unit she had attempted to strangle herself with her own hands. I had angrily told them, that they must see this as a reflection of Abbi's feelings about being on the ward, and her treatment. I remember the staff laughing in response and informing me that I was wrong and that in fact her behaviour actually demonstrated that Abbi felt secure enough to explore these feelings in safety. It was this same night that I had a conversation with [Psychologist G], and someone called [I/S] (whose surname escapes me) - I had angrily told them that they had no idea what it was like to have a

child on this unit, and they replied, equally as angrily, that I had no idea what it was like working with these children, and how they 'took it home with them'.

- Abbi continuously being promised leave (either home or escorted off the premises) - such as the time they promised her to take her to Asda to buy a CD that she wanted - but then due to staffing issues or the inability to keep her Debit card secure, the promised leave was then refused. Abbi had often agreed with the staff to behave in a certain way for many days before being given this treat/ reward and so when she subsequently self-harmed out of frustration because of the reward not taking place, they then penalised her for self-harming (e.g. usually by withdrawing further planned home leave or events she was looking forward to such as bowling).
- **Psychologist G** the clinical psychologist, accused me of lying about Abbi's autism diagnosis. Incredulously, when I offered to show him the autism diagnosis papers from both Stockport and Essex, I recall him laughing and telling me that if Essex had diagnosed her it would be on his system! He then walked off and left me in the corridor.
- On one occasion I was in a meeting with **Psychologist G** and Dr **[I/S]**; they were sat together on one side of a very large room and I was sat at the other end of the room; there was no table between us, only a large empty area. When I started to ask questions, I said that I needed to record what they were saying. They questioned me about this and I explained that I later wrote down what they said. At this point they both looked at each other, as if aware of some prearranged agreement, and in silence stood up and walked out of the room. They did not come back in, and no one came back into the room to tell me what was happening. After some time I got up, left the room and walked into the corridor. There was no one around, and all I could do was bang on the door for reception to let me out. They would not engage with me, and I had to leave the premises, but not before taking a photograph (with my phone) of the **Larkwood rules** which happens to be on their reception desk for some reason. The rules that I photographed state the following:

"LARKWOOD

Unit rules and expectations

As a patient at Larkwood you will spend a lot of time in the company of other young people and staff. We ask everyone to respect a number of unit rules to help the process of living together.

- *NO BULLYING*
- *Verbal and physical aggression will not be tolerated*
- *No physical contact between patients*
- *Good manners are expected at all times*
- *Do not swear or use language that can offend*
- *Respect yourselves, others and the ward*
- *Dress appropriately in ward areas; this includes clean clothes*
- *Night wear must not be worn in communal areas*
- *Blankets and sheets are not to be in communal areas*
- *Pencils only in communal areas*
- *Keep bedrooms and ward areas clean and tidy at all times*
- *No toiletries to be kept in bedrooms/bathrooms*
- *No lpods or kindles etc... are allowed out of the social area*
- *Never go into other peoples bedrooms*
- *There will be no lying on the furniture*

- *To remain in day areas during the hours of 9am and 9pm*
- *You are expected to follow your individual care plans at all times*
- *Everyone must attend school and community meetings. If this doesn't happen you will spend time in de-escalation*
- *Everybody will wash their hands and use the bathroom before meal times*
- *No fizzy drinks or outside food are allowed on the unit*
- *Breakfast will be served between 730am and 830am. If you miss breakfast you will be asked to wait until next snack or meal time*
- *When meals are being served you are to only to come to the serving hatch one at a time and remain in dining area until everyone has finished eating and cutlery has been counted back in*
- *Telephone access will be granted between the hours of 630pm and 9pm only*
- *Radio channel hearty only can be used at nurses discretion*
- *Milky drinks will be offered after 8pm only*
- *Lights out Monday-Thursday including Sunday 10pm*
- *Lights out Friday and Saturday will be 11pm*

Thank you for respecting these rules"

- The next time I visited Abbi there was a sign up saying no phones were allowed and they all had to be left with reception 'before seeing your child'. I complained about this as I knew Abbi enjoyed seeing photographs of our animals and family a great deal, it was how she remained and felt connected to the family. I did feel that these rules spoke more to a prison setting than a therapeutic environment for young people. Why should telephone access only be between 6.30pm and 9:00pm and why can they only have milky drinks after 8pm. Abbi loved hot chocolates. It was one of the tools **the school** used to help her to regulate her emotions and calm down enough for them to discuss things with her. Why was she not allowed to lie down on furniture and why could she not lounge in her pyjamas if she wanted to? Abbi loved her pyjamas and had many sets – she was even buried in her Winnie the Pooh pyjamas. Why would she be escorted to "de-escalation" for not attending a community meeting? This seems punitive in manner. Abbi was not happy talking in front of others. Where is the personalised care in this set of rules?
- Having a shocking conversation with **[I/S]**, the modern matron of the unit, - I told her of my incredulity at the way Abbi was being treated and the stories that Abbi was telling me of the poor treatment she saw. Sadly, it was a bit of a theme, but I was regularly laughed at by the staff and Lizzie laughed at me too. She said who did I think people would believe, her and her staff, or the young people that were in in the ward for mental health reasons!
- Being told that I did not engage with services. I actually went to everything I was asked to go to and voluntarily attended others. I believe it was because I started to question them that I was told this (presumably other services were also told that I was not engaging).
- Abbi's sister (Charlotte) rang the patient phone to speak to Abbi: she spoke to one of the staff named **H**, who told her that Abbi was asleep. At this point we didn't believe anything the unit said, and I phoned the office instead of the patient phone and spoke to somebody different **[I/S]** who said that Abbi was awake, in her bed space colouring and waiting for the call from her sister because Abbi's sister had promised to ring. I phoned Charlotte back and gave her this message. Charlotte tried to call the patient phone again, and unfortunately **H** picked up the phone again, only this time he shouted at Charlotte and told her that he didn't care what she said, she was not speaking to Abbi.

- I watched a young person in the section 136 room through a window who was being restrained by staff - there were 2 people sat on top of this young person, and they had his arms bent right up his back. In addition, one person had their knee in his back (I was in that area as I had taken the dog to visit Abbi).
- Abbi having her coping mechanisms removed, such as her DS, as another young person had swallowed a battery. I felt this showed a great lack of person-centred care – why was there a blanket policy of removing items rather than a risk assessment and altered care plan for an individual needing extra support? On an occasion, Abbi self-harmed because she didn't have her DS – as a consequence of her self harm her home leave was removed. The staff constantly failed to realise that her self-harm was as a direct result of their behaviour and actions.
- Abbi's belongings regularly going missing, such as her iPad, her necklace, iPod, charging cables, clothes - belongings that meant a great deal to her. This would result in further self-harm, followed by subsequent "punishment" with no acknowledgement that their treatment (of not looking after her possessions) had been the root cause of that episode of self-harm.
- I once asked if a relative could visit and cut Abbi's hair as they were a qualified hairdresser, and Abbi desperately wanted her hair to be cut. The unit agreed and Abbi's hair was cut, however the next time I went in the unit were big signs up saying that no haircuts were to be given in future. Did they think about how this would make Abbi and I feel?
- The longer Abbi stayed there, the more I got to see another side of the staff. I remember Abbi's 18th birthday was spent in the unit: she was not allowed to come home, and a member of staff had to be in the room with us whilst we gave her presents and her birthday cake. I think it was a weekend - the staff seemed inappropriately relaxed and they were joking around with each other as if they were in a school playground. I remember feeling as if I was a fly on the wall and wondering if it was like this all the time.
- Other parents telling me that they too were being accused of horrific things which they hadn't done - this seemed to be a very common theme at that time.
- Staff not ringing me back when they promised to.
- Unplugging the ward phone so parents could not phone and speak to their children. It was actually a member of staff who told me this. Apparently, when the phone got on their nerves, they simply unplugged it. I also seem to recall that I could only to speak with Abbi between the hours of 6:00 PM and 9:00 PM. I do not know why.
- Abbi telling me she had been force fed rhubarb crumble. She said that she didn't want to eat it as apparently another young person had found a snail in their meal. She said she was held down in a chair by her wrists whilst another person held either her nose or mouth, until she opened her mouth - they then they force fed her.
- When Abbi was moved from St Aubyn Centre to the Christopher Unit, **Psychologist G** kept visiting her - Abbi had to ask the Christopher unit staff to stop him from visiting her.
- Abbi's key worker **[I/S]** apparently shared a "secret" with Abbi- Abbi told me that **[I/S]** had said she wanted Abbi to live in a house away from her family. I shared this information with the ward and not long after this, **[I/S]** was removed as Abbi's keyworker.

- I kept informing the unit that I wanted a second opinion. The staff eventually gave in, but would not allow me to choose who should give the second opinion - they said that they would choose and from memory they chose somebody [I/S] **called Dr [I/S]** I think he worked for Colchester CAMHS. I saw **Dr [I/S] and he reassured me** that the unit were not trying to remove Abbi's autism diagnosis and that they were treating her appropriately. I remember writing down what he said and then discussing it with staff at the St Aubyn Centre. A few days later I had a phone call from **Dr [I/S]** who was very cross with me, and said I could not go around quoting him!
- On admission, the St Aubyn Centre had categorically reassured me that the Linden Centre was not appropriate for Abbi and they would not be discharging her there – in my view, this was inappropriate due to being a mixed ward. Yet this was exactly what happened when she was transferred to the Christopher unit at the Linden Centre.

57. I strongly disagreed with the decision to move Abbi from Longview ward to Larkwood ward in the St Aubyn Centre. When Abbi was initially admitted I visited her daily until I could not afford to do so. I then visited her every other day until I could not afford to do that either. This led me to visiting her usually twice a week. Abbi had shared with me that she would be discharged from the St Aubyn Centre before Jessie J came to open it and that this made her sad. At that time Jessie J was Abbi's idol, and she was desperate to meet her. I still believe that Abbi deliberately started to find ways to try and stay longer in order to meet Jesse J. In the end, the unit was opened by Rebecca Adlington, and I remember Abbi's huge disappointment. By then, the damage had been done, and Abbi had learned new ways of harming herself and had started to abscond.

58. It appears that the below sad diary entry refers to the incident I recall when Abbi was refused leave from Larkwood to come back to my house overnight for her birthday as I was told it would be like granting her a holiday.

59. Abbi's birthday is 23 June, but the following extract from her white diary with owls is recorded under "23/12/13". It states:

"...Today on my 18th birthday...it wasn't the best place spending your 18th birthday in a mental hospital but I enjoyed seeing everyone hopefully soon I can be at home..."

Christopher Unit (PICU) Linden Centre

60. **Dr C's** statement dated 7.5.24 states that the dates of this admission were from **24 September 2013 – 30 January 2014**. Her statement states the following regarding this admission:

"...16. On the 24 September 2013 Miss Smith was transferred to the Christopher Unit when she turned 18. The Christopher Unit is an Adult Psychiatric Intensive Care Unit (PICU).

17. On arrival to the Christopher Unit, Miss. Smith was calm and quiet and did not show any signs of distress. However, two hours following the admission and whilst lying in bed in her room, she put a ligature around her neck after which she was banned from staying in her room during the day and had to be put on 1-2-1 level observation by the nursing staff. During the following three weeks, Miss. Smith's tendency to bang her head against the wall reduced in frequency and following four weeks of being admitted to the Christopher Unit, Miss. Smith stopped self-harming and within two weeks, she changed into a different person. The level of observation was gradually reduced and stopped causing any management problems. She no longer required any psychotropic medications and engaged well with the team. She used her Section 17 leave appropriately and enjoyed extended home leave without any problems.

18. At the beginning of her admission to the Christopher Unit, Miss. Smith was referred to the special behavioural unit at the Royal Bethlem & Maudsley Hospital. However, in view of her improvement and the closure of the above-mentioned unit, it was decided that Miss. Smith no longer required such referral and on the 24th of January 2014 she was taken off her Section 3 of the Mental Health Act, became informal and was discharged from hospital on the same day.

Final Diagnosis:

- Autistic Spectrum Disorder, F84.0
- Mental Retardation (to be concluded by a specialist)
- Discharged on no medication

Discharge Plan:

- Miss. Smith was referred to the National Autistic Society.
- Miss. Smith was referred to the outpatient department for follow up.
- Miss. Smith was referred to [I/S] Social Worker, for assessment of her needs..."

61. The Christopher unit was much smaller, darker and more old fashioned. It had a small communal area and bed spaces off the hallways. Inside the communal area is a separate room that I called the glass house. It was a room that had glass windows all the way around, so that one could see inside at all times. There was also a much smaller separate room with a couch. I spent time with Abbi in both of these rooms at different times. I was never allowed to see her bed space.

62. I do not believe this unit was able to meet Abbi's basic needs. I remember that there was a gym there, but Abbi said it was never open as there was not enough staff to facilitate it being used. There were many times when Abbi told me that she wished to use the gym but had been informed that she could not as there were no members of staff to supervise her. The outdoor space was not sufficient for any worthwhile exercise. My view is that the patients in this unit must feel like rats in a laboratory cage.

63. I do not believe that this unit was a suitable environment in which to provide inpatient mental health care – it was too old, too cramped, too small, too dark and quite frankly I feel that prisoners would have access to more outdoor space than patients on this unit. There was a small courtyard that was smaller than a basketball court and simply had wire surrounding it, with barbed wire encircling the top. How is this suitable for one's mental health?

64. During this first admission to the St Christopher's Unit, it seemed quite positive. Abbi started to recover almost as soon as she was admitted. The consultant, who I think was Dr [D], allowed me to see Abbi unsupervised and granted home leave - the difference this had on Abbi was like night and day. I remember in a CPA I attended (which [Abbi's] school attended too), Dr [D] explained to me that my daughter had autism and had anybody ever explored that with me. This doctor also said that she probably had learning difficulties too and these should not be "underestimated". He went on to explain he had trained under Lorna Wing Centre for Autism and had in depth knowledge and experience. I remember everyone else in the CPA looking surprised; his colleague said that there was no mention of this in Abbi's notes from the St Aubyn Centre, and I had to explain that not only had Abbi already been diagnosed with both autism and learning difficulties but that the school that Abbi attended, before she was admitted to the St Aubyn Centre, was one for children with profound and multiple learning difficulties. I remember the [school] staff speaking to me afterwards and saying that they needed to explain to the head teacher how the earlier unit had said Abbi didn't have autism, and this unit is now saying that she did! I believe Abbi was fully discharged from this unit only a few months after her admission and I remember Dr [D] saying that he was not going to step her down by admitting her into Galleywood ward as

he thought this was not the correct environment for her, and instead she was to be discharged directly into my care.

65. Christopher Unit was a mixed ward, and I would raise questions as to whether a mixed ward was a suitable environment for Abbi. Essentially, I believe it was Dr [D] who was the catalyst for Abbi's recovery, and not necessarily the ward. I had highlighted numerous times how vulnerable Abbi was in situations and wards such as these.
66. During Abbi's subsequent admissions here, Dr [D] was no longer there. After Dr [D] I would say that this unit did not assist in Abbi's recovery at all, and in fact was actually very damaging.
67. An extract from Abbi's plain black diary states:

"...I am now in the Christipher unit in chelmsford... I came on the 24/9/2013 since I have been here I have not been coping so well and I fear I will be in hospital for christmas I have already ligitured with a sock quite tight I have tryed to head bang so I have had a few IM'S I am so sick of my life I am now waiting for a bed at the Maudsley which is in London so can get the help I need but I already know I can never get better so thats all I really want to say inside I am screaming for some HELP. So much has happend and I think it's all my fault I look in the mirror and it's not me that I see anymore It's like a Devil that's inside me I hate being restrained but sometimes head bangings the only thing I know how to do..."

The subsequent time period was following her discharge from Christopher Unit to me, then admission to The Priory Hospital, Chelmsford.

68. I found a document which I appear to have created on 11.09.2017. I am not sure whether I sent this document out, however it does contain good insight into my concerns. I will refer to the contents of this document in various places and will identify it as 'document I created on 11.09.2017'. With regards to the time period following her discharge from the Christopher Unit, this document states:

"...Following her discharge I had sole care of Abbi and we lived together in a two bedroomed flat in Chelmsford. Abbi required a lot of support and although she had been assessed and awarded monies for hiring a PA, Abbi did not want this support and instead wanted me to provide it. I discussed this situation with Social Services and was advised that I couldn't make Abbi accept the support from a PA as she was over 18 and entitled to make her own decisions. I queried this and pointed out that unless I facilitated her days out and organised her time, Abbi would do nothing but get up in the afternoon, watch tv or sing in her room and I wanted more for her than this; I wanted her to engage with life. I also felt it unfair as Abbi required so much support that I was unable to work at the time. Although the Government were trying to force me to return to the workforce, I could not split myself in two and manage both. I asked for a Carer's Assessment and during this, the Social Worker informed me that the only way to make Abbi accept the help was for me to live separately from her. We had lived together in this situation for eighteen months during which time Abbi did not self harm or threaten her life in any way at all.

The Social Worker came to our flat and told Abbi that we needed to be housed separately, as staying in the flat was not possible for either of us. She explained that Abbi would be supported in settling into new accommodation which would facilitate her in engaging more fully with an independent life. However, the council said that the Social Worker could not promise this as they didn't feel that Abbi had the level of need which other professionals could see and prove through a number of assessments which had been carried out previously.

That evening Abbi took an overdose of tablets. She was taken via ambulance to Broomfield Hospital and after assessment by the Mental Health Team was admitted to the Priory Hospital in Chelmsford. I had many phone calls from Social Workers demanding that I come and take Abbi home and rightly or wrongly I decided to manage the situation in the best way I could by informing everyone that Abbi needed a supported tenancy in order to engage with life and that living with me was not providing her with any quality of life, it was merely a shadow of a life and that I was going to use this situation in order to insist that someone assess Abbi and find the correct support and placement for her.

I wanted to be her mum not her carer..."

69. With regards to this period Dr [C]'s statement states:

"...19. Miss Smith was discharged from the Christopher Unit (Intensive Psychiatric Care Unit) in January 2014 to her mother's address. She was subsequently reviewed in the Outpatients clinic and also by her care coordinator regularly. It was reported that her mental state remained stable. However, she did not attend her appointments since the beginning of 2015.

20. Miss Smith was assessed by the Access and Assessment Team on the 3 October 2015 following her taking an overdose of [US] Paracetamol tablets. At the time, Ms Smith revealed that she has been feeling low for some time with difficulty sleeping and a low appetite. The stressors at that time were not getting on well with her mother; mother separated from her previous partner and found a new partner. Her mother decided to move to accommodation in Romford. Due to this Miss Smith was looking for alternative accommodation. She was not regretful of her overdose, and she did regret that it did not work. Hence, an informal admission was considered.

21. Initially she was admitted to The Priory Hospital. During her stay in the Priory Hospital, she did attempt multiple times of ligatures, head banging and attempting to leave. Hence, on 16th October 2015 she was assessed under the Mental Health Act. Considering her risky behaviour and a partial insight she was placed under Section 2 for a further assessment..."

70. Regarding the above section of Dr [C]'s statement, I make the following comments:

- a) With regards to paragraph 19, and the fact that it states "she did not attend her appointments since the beginning of 2015", I took Abbi to every appointment I was aware of, but if they sent the letter to Abbi herself and she got to the post before me, it is possible she "chose" not to tell me about the appointment but I never knowingly missed taking her anywhere and indeed fought to get her as much support as I could.
- b) With regards to paragraph 20, it was very difficult for me to read the contents of this paragraph. Abbi and I always got on well. Yes, she objected to me asking her to get up before midday or to tidy her room, but we had an amazing relationship. I did not simply "decide to move to Romford" with Greg. The Social Worker had told me that if I wanted Abbi to have any support we *had* to live separately, I had gone to Social Services to ask for help, yes, as I was not in employment as caring for Abbi full time and the DWP had told me that I needed to attend sessions with a work coach to get back into work, these were with INGEUS at the time. I felt scared about doing this and leaving Abbi with no support. I was also exhausted with everything I tried to do for Abbi, ultimately, I just wanted help but not to live separately. I never saw my life with Abbi and I not living together until that SW told me there was no other option. That was why I insisted she made a home appointment to tell Abbi so that Abbi would not think I was rejecting her in any way. See how everything always gets turned round on me and I take the blame from everyone. I did make mistakes, but I am not to blame for all of it.

71. With regards to Priory Chelmsford (according to Dr [C]'s statement this was from **5 October – 20 October 2015**). My memory of events is as follows:

- Abbi was initially seen at Broomfield A&E in Chelmsford after taking an overdose.
- Whilst in A&E I had received calls almost simultaneously, one from the social worker telling me that my daughter was fine and to please come and collect her, and another from a nurse telling me that my daughter had ripped her cannula out, was running through the hospital and down the street, and that hospital staff and the police were chasing her. I asked for Abbi to be assessed at this point because I wanted her to receive appropriate support within the community to live safely, securely and to enjoy and engage with life - I will never forgive myself for this gross error of judgement on my part as she was then lost to the system for many, many years only to be "released" from inpatient institutions in 2019. Generally, I had more concerns about decisions to admit Abbi. None of these psychiatric units seemed particularly appropriate, and many did more damage and harm than good. The only one Abbi ever spoke positively about was the Priory in Potters Bar (further information below).
- From Broomfield A&E, Abbi was then transferred to the Priory in Chelmsford. I was never able to see this ward. I never got further than the car park. I cannot remember if Abbi did not want me to visit or I was not allowed to go in. Abbi came out to me though and we walked around the car park and I gave the things I had bought in for her.
- With regards to Abbi's admissions from 2015, I generally have little idea about the care she received/what happened to her - I would visit her but would be told very little. Abbi apparently told the clinicians she did not want me to know anything. I find this hard to believe but also hard to understand. I was Abbi's primary carer and had never shown anything other than love and support. I only ever wanted the best for her and for her to live her life the way she wanted but in a meaningful way which allowed her to engage with society. I wanted her to enjoy life.
- Accordingly, I have no idea with regards to what activities (if any) were available, and if they were engaging or meaningful. I also do not know if Abbi had access to outside space. I do recall taking some things for Abbi and she also came out to see me - we had a walk around the car park.
- I believe this ward had a detrimental effect on Abbi. I remember Abbi telling me that the psychiatrist had told her that the Linden centre was not an appropriate setting for her, and she would stay at Priory until suitable accommodation was found. When Abbi was then recalled to the Linden centre and I think that this is when she was able to abscond from the unit and was found on the bridge. If I have recalled correctly, then clearly this unit would have also had issues with safety.
- I also remember Abbi making remarks about a male member of staff behaving inappropriately with female patients, although she never elaborated in what way.

72. With regards to this time period, the document I created on 11.09.2017 states:

"...Abbi is a chameleon and mirrors her surroundings and as soon as she was in the mental health system her decline started. The Priory promised Abbi that they would help to source appropriate accommodation for her and that she would stay with them until that was sorted. However, in under three weeks Abbi had been transferred to the Galleywood Ward in the Linden Centre at Broomfield Hospital. This was the same Galleywood Ward that had been deemed inappropriate just 18 months earlier because of Abbi's vulnerability and learning difficulties,

when, following discharge from the Christopher Unit at her last CPA, I had been specifically informed that the step down to the open ward would hinder Abbi's progress and that they were taking the unusual step of avoiding this..."

According to Dr [C]'s statement Abbi was then transferred to the Galleywood Ward at the Linden Centre on 20 October 2015.

73. Galleywood ward admission was from **20 October 2015** until transfer to Potters Bar Clinic (Elysium Healthcare) on **25 January 2016** according to Dr [C]'s statement. Dr [C]'s statement includes the following:

"...22. She was then transferred to the Galleywood Ward at the Linden Centre on 20 October 2015.

23. Following her transfer, Miss Smith presented with multiple ligature attempts and on one occasion she required transfer to Broomfield Hospital for further assessment. She continued to present with the head banging behaviour despite being on Level 3 Observations. Due to this she required multiple rapid tranquilisations. During the interview's Miss Smith did not wish to stay in the hospital but she found it extremely difficult to reflect on her risks. Although superficially she had agreed to cooperate with the therapeutic interventions, she continued to pose a risk to herself, and she was not able to use the resources on the ward in order to minimise the risk. Considering this she was placed under Section 3 for further treatment on 11th November 2015.

Medication during this admission:

- Fluoxetine 60mg in the morning
- Quetiapine 50mg nocte
- Clonazepam 1mg in the morning, 2mg in the afternoon, 2mg nocte.
- Haloperidol orally and intramuscularly within the written limits PRN
- Lorazepam orally and Intramuscularly PRN within the written limits
- Promethazine 25mg to 50mg up to BD PRN orally.

Diagnosis:

- Miss Smith suffers from Emotionally Unstable Personality Disorder on the background of a mild learning disability and Autistic Spectrum Disorder..."

74. With regards to this admission, I note that the document I created on 11.09.2017 states:

"...Abbi hit the self destruct button and spiralled out of all control on Galleywood Ward. She absconded regularly, she ligatured regularly and she overdosed when other patients smuggled drugs onto the ward. There were several occasions when the Police were called to search for her and one memorable incident involving Police Dogs and helicopters searching for her in December 2014 when she had been missing for approximately 10 hours.

During her time in Galleywood Abbi was transferred for a week to a MH unit in Basildon. I was informed that this was in order to disband a mob of patients that were 'controlling' Galleywood. I clearly remember the phone call from Galleywood to tell me that this was due to 'mob mentality' on the unit that needed to be broken up. I got the impression that Abbi was sent because of her vulnerability. Upon Abbi's return things continued to deteriorate and there were many admissions to A&E following serious self harm and attempts to take her own life..."

75. Abbi had another admission into Galleywood ward in February 2022 and later in my statement I have gone into further detail regarding her care during that admission. In the meantime, I will state

now my general view of Galleywood ward further to both admissions - by way of explanation I have listed below some incidents of concern which arose during either or both admissions.

76. I don't have much recollection of the ward environment, despite the fact that I visited Abbi a few times. I think my brain has tried to block it out. I remember it being an open ward with patients milling about looking very bored. I remember feeling quite nervous being in there.
77. I remember that there was never any staff to be seen! I remember waiting ages to be allowed onto the ward – it felt as if there were not enough staff to come and get me, or as if they didn't know I was waiting. There was minimal interaction with staff either towards me or Abbi during my visits there.
78. With regards to whether the ward environment met Abbi's basic needs, if safety is to be included in her basic needs, then my answer is that it did not meet her needs.
79. I believe that every admission into Galleywood ward, was both detrimental and damaging to Abbi in a multitude of ways. She never had anything positive to say about this ward, only negatives.
80. There was a flaw in their security as Abbi found out that she was able to set off the fire alarms which released the fire doors / security locks – allowing her to abscond.
81. She was able to abscond several times from this ward, including:
- I believe that there was an incident in December 2015 when Abbi absconded and police dogs and helicopters were needed to look for her in the winter – she was found in a ditch in a field in the early hours of the morning.
 - The incident when she absconded from and was found in McDonalds the following morning with blood running down her face. The staff gave her a coffee and called the Police.
 - The incident when she was given leave and absconded – she was then taken advantage of (allegedly) by a former teacher [I/S] who plied her with drink and cocaine and told her he was going to “bust her out of there”.
82. Abbi was also able to ligature here a number of times: I believe this is the unit who had to do CPR on Abbi in her bedspace, after she was able to ligature.
83. Abbi was able to take an overdose from another patient who had smuggled clinical drugs in.
84. I was advised by staff of a “mob mentality” which they struggled to break up and so needed to send the patients to different units to break it up.
85. Abbi spoke of bullying on the ward - they allowed Abbi to be bullied by another patient which resulted in her calling me on the phone and crying. Crying was an unusual occurrence for her. I tried to highlight to staff that this was happening, but of course I was not listened to and Abbi ligatured that night.
86. Even though I expressed to staff that Abbi required additional support, due to her diagnosis of autism and learning difficulties, they ignored me and allowed her leave with no support. This resulted in her both absconding and trying to overdose whilst out - this happened several times. When staff finally worked out I had been telling the truth and that Abbi required additional support when outside, she was only allowed half an hour leave a day due to staff shortages.

87. I was told in confidence, by an ex member of staff (who has not come forward as far as I am aware), that on one occasion the ward manager warned her not to engage with Abbi "as she was possessed" - [I/S]

[I/S]

88. I do not feel she was supported on this ward. They failed her numerous times before ultimately effecting, what I consider to be, their final failure by sealing her death warrant and discharging her inappropriately (details regarding this are later in my statement).

89. An extract from Abbi's red A4 folder states:

23.10.2015

"...Gallywood ward ...I did a massive attempt to take my life...I ripped loads of cords off my clothes and tied them around my kneck I waited until my checks had just been done and then I did it ...I just wanted the pain in my head to stop I just wish I was dead...when they found me the quickly got the scissors and cut them off but I wasn't breathing so they put me on a lot of oxogen and they called the ambulance all my blood vessels had burst in my face ... then my transport was here so I went in the back of a prison cage all the way to Colchester. It was horrible..."

90. This is the ward where in one of the videos Abbi made, she describes the fact that there are no groups, there is no structure and that no one gives a sh*t or cares. She said it was like she was a ghost. I have further discussed these videos later in my statement.

91. In conclusion this ward did not provide Abbi with any recovery or rehabilitation support. Again, this was a damaging and detrimental admission. To reiterate, this is the ward where the senior member of staff warned the bank member of staff that Abbi was possessed! This is the ward where Abbi herself recorded videos and posted on Facebook, stating that staff didn't care and that there was nothing at all to do. From the conversations I had with her, and from subsequent conversations with her friends, I think she spent the majority of her day watching television, playing her DS, and harming herself. I do not recall any outside space.

Potters Bar

92. Dr **C**'s statement states that the dates for this admission were **25 January 2016 – 17 March 2016**. The statement further states:

"...25. On the 25 January 2016 Miss Smith was transferred from Galleywood to Potters Bar Clinic which is under Elysium Healthcare. Miss Smith was transferred due to challenges with managing Miss Smith's risk in an acute open ward setting including self-harm, overdose and alcohol use..."

93. The document I created on 11.09.2017 states:

"...It was finally agreed that Abbi needed more support than Galleywood could offer and she was transferred to a PICU - Priory Hospital in Potters Bar. Here, there was a calm, structured environment and they recognised the support Abbi needed. The self harm started to recede almost immediately and the staff engaged with both myself and Abbi. I felt positive for her future for the first time in months. Slowly Abbi started to improve and then one day weeks later I took a call from a member of staff who said that Abbi had been recalled to the Linden Centre with no notice and that she was returning there but to the PICU this time instead of the open ward. Abbi was returning to the Christopher Unit for the second time in two years..."

94. This unit felt quite welcoming. I remember seeing Abbi in a large communal area where there were young people sitting down watching TV who to me looked like they felt comfortable. When I saw Abbi we played games in the main room – this is where there were other young people sitting watching TV. Abbi also had her DS and watched videos on her portable DVD player.
95. I remember Abbi telling me that this was the unit she felt most comfortable in. As I recall they were able to do such things such as requesting takeout pizza and having more freedom with their phone and belongings.
96. When I visited, this ward gave me the impression of being a friendly and supportive environment and one that I believe would provide appropriate inpatient mental health care.
97. This is the unit where I think Abbi felt most supported, was most engaged in her recovery. There was interaction with staff. I would therefore say that her basic needs were met. I recall Abbi telling me about occupational therapy, and such like, on this ward.
98. Sadly, in my view the only ward environment which had a positive impact on Abigail was this one. Abbi always spoke about how this was the only unit where she felt she was listened to and supported.
99. I recall a conversation with staff at this unit where they telephoned me saying that Abbi had been recalled to the Linden centre and that again, transport had been sent for her which was like a cage and that this shocked them.
100. The document I created on 11.09.2017 states:

“...The Priory staff were very alarmed and felt that the move was not in Abbi’s best interests. They were very concerned that if they were to transfer Abbi there would be two members of staff to escort her because of her high level of absconding but told me that the Christopher Unit staff had casually arrived and walked Abbi out to a cage in the back of a van where she had been locked like an animal for the journey back to Chelmsford. ..”

Christopher Unit, Linden centre

101. According to Dr [C]’s statement this admission was from **17 March 2016 – 21 June 2017**. She was transferred here from Potters Bar. With regards to this admission, Dr [C]’s statement states:

“...25. Miss Smith was transferred from Potters Bar Clinic to the Christopher Unit, PICU EPUT ward. She remained on the Christopher Unit until 21 June 2017.

26. Miss. Smith was transferred to the Christopher Unit on the 17th of March 2016 from the Psychiatric Intensive Care Unit (P.I.C.U.) Priory Hospital, Potters Bar.

27. She had been originally transferred from an open ward (Galleywood Ward) on the 25th of January 2016 when it was felt she needed containment within PICU setting due to frequent episodes of self-harm and attempts at strangulation. Whilst on Galleywood Ward, she had engaged in self-harming behaviour with multiple episodes of ligaturing and head banging and had, on one occasion, absconded from the ward by triggering the fire alarm. During her admission at the Priory Hospital, her self-harming behaviour continued to escalate, and they were sufficiently worried about her, to increase her level of observation to constant monitoring by two nurses. There was also a discussion with commissioners about referring her to a Personality disorder unit although there were significant concerns about her ability to engage with therapy sufficiently enough to lead to a change in her presentation.

Medication during this admission:

- Fluoxetine 60mg daily
- Quetiapine 300mg nocte.

Plan during admission:

- Continue individual weekly psychology sessions
- Proposed plan to transfer to specialist personality disorder unit once a bed becomes available..."

102. I do not remember understanding or being given a reason as to why she was recalled to the Christopher unit.

103. The document I created on 11.09.2017 states:

"...Again Abbi deteriorated. She was on a ward filled with mainly older men. There was one pay phone which only the staff could plug in and one television. There were no activities, no trips, nothing to look forward to and no hope. Abbi was regularly subject to inappropriate advances from male patients on the ward. She would inform me and I in turn would inform the staff. The staff also didn't seem to appreciate Abbi's vulnerability or her learning difficulties and couldn't understand why when they kept giving her unescorted leave, Abbi would abscond.

Abbi had three serious episodes of absconding from the Christopher Unit (although many that again required the Police to be notified and to search for her and bring her back). On one occasion Abbi was found in a park by a member of the public. She was drunk and had taken an overdose. An ambulance was called and she spent the night in A&E.

On another occasion she was able to abscond and phone a man she knew. He was in his forties and I had already raised a safeguarding concern with the Christopher Unit staff about this gentleman abusing Abbi's vulnerability. He plied her with class A drugs and alcohol and the Police had to remove her from his home, fortunately before any further harm could happen to her. Again she was taken to A&E where she had to have her stomach pumped and have ECGs in order to ascertain the potential damage; luckily there was none as far as I am aware.

On the last occasion Abbi was able to abscond this February gone. She had been taken to a clinic for an external MH appointment. She ran from a member of staff and I am informed that the member of staff cannot give chase, they merely have to let the patient go. It was 1pm when Abbi absconded and at 7pm I was finally informed. Every time a car drove past my home, I was convinced that it was the Police turning up to tell me they had found a body and at 3am I found myself in my garden staring up at the sky wondering if it was too cold for her to survive the night? I was informed the next day that Abbi had wandered into a McDonalds in Widford in Chelmsford at 7am the next morning, having been out for 18 hours. She had been headbanging and her head must have been in quite a state, as the McDonalds staff took one look at Abbi and sat her down, gave her a cup of coffee and phoned the Police.

Following this, the last incident to occur at the Christopher Unit was the episode where an elderly male gentleman took to walking around the unit with the remote control for the only television hidden in his pocket. He also didn't like other patients using the one and only telephone on the ward. One day Abbi was using the phone and he came over and pushed her. Distressed, Abbi went outside and a member of staff went with her and reassured her that she was in no way to blame for the incident. The member of staff pointed out to Abbi that Hollyoakes was just starting and that it was her turn to watch the television. The member of staff took Abbi inside and asked the male patient for the remote control. He stood up and punched my daughter full in the face. She ended up laying on the floor bleeding and all this took place with the member of staff stood with them and witnessing it..."

104. I have already given some of my views on the Christopher Unit. I would like to reiterate / add the following:

- There was very little outside space - a very small courtyard surrounded by a chain link wire fence with barbed wire at the top, bent inwards, presumably to stop people from climbing out. Abbi had very little activities here. I tried to visit and watch DVD's, or play games with her, other than this I think she sat and watched television. This is what led to her being punched by another patient, as she had wanted to watch one of her programmes that this male patient had not wanted to watch. Further to being punched in the face she was left with bruising and a wobbly tooth. The other patient was male and I think in his fifties.
- There were many occasions that Abbi told me she wanted to go out for a cigarette (smoking was something she started to do whilst an inpatient) but that there were not enough staff to let her go outside.
- Similarly, she would also tell me there were not enough staff to allow her access to the gym.

105. An extract from Abbi's purple 'I'm loveable!' book states:

31.07.2016

"...Today I went on a picnic ...I had 3 hours leave ...It was so nice being off the ward..."

106. Extracts from Abbi's pink diary with butterflies state:

03.08.2016

"...saw the Dr and i told him how this place needs improving and how ther is no treatment or care on the ward..."

07.08.2016

"...I tied loads of cords round my kneck as I was having a really bad day and I passed out in the bathroom..."

08.08.2016

"...i just cried and headbanged..."

17.08.2016

"...had my review with the Dr that no one likes and i talked about how this place is shit and how theres no care going on the ward and something needs to change and then I mentioned my leave and he swas like your not well at the moment so you can't go on leave and I had a bad day I was crying all day and I had a blade in my room so I cut my arm..."

107. Extracts from Abbi's pink diary with butterflies continue to state:

20.08.2016

"...I had to go Ane last night as I cut all my arms open so I had to have my arm glued..."

24.08.2016

"...had my review with the Dr and i said rather then look at notes how about you listen to you patient and he just said I don't have to answer that. I really hate that smug man and I just walked out and said get a different job and then I started crying so i rang my mum and told her I have no support in my review so I have to fight for what I want and it's so draining..."

- a) With regards to the above entry about a review with the doctor, I want to explain that I tried numerous times to access advocacy for Abbi as I was working full time by this time, but it was expected that the person refer themselves for advocacy for each and every meeting. This was far beyond Abbi's ability and gave her no consistency even if I were to do it for her. She would be having to engage and tell her story time and time again.

12.09.2016

"...Today Dr [I/S] wasn't in so it pissed everyone off as he is never here and when he talks to you he smirks as if it's a joke. I really can't stand that man..."

15.09.2016

"...So I'm getting accused of taking drugs ... because my mood has changed it's so stupid just because I'm having a laugh..."

22.09.2016

"...I bought some coke of him ... I ran off in the woods and I waited until it was dark ... stopped off at the shop and I got myself a pack of fags and a bottle of Vodca. And then we pulled over and we did some coke and then I drank the whole bottle and then the police came and handcuffed me and pinned me to the floor and when the police took me back I was so out of it I was scared and just didn't reconise anyone because of how pissed I was I could't even walk ... I was in hospital..."

23.09.2016

"...still in Broomfield and I had a massive hangover and yesturday all the staff pinned me on the bed and I couldn't wee so I had to have a caferter in..."

24.09.2016

"...I felt so low so I started headbanging and crying so everyone came in ... they pinned me on the floor and injected me..."

25.09.2016

"...I came to my room ripped a sheet up and tied it really tight around my kneck...they couldn't get it off as it was so tight but when [L] cut it off I stopped breathing...the Ambulance came and put me on a strecher but I was ok and I came back in a wheel chair. The securaty guards walked me and I tried to run but they pinned me on the floor..."

28.09.2016

"...I'm just sick of being here and I'm just sick of everything...I've just been in the system to long and because I'm the only girl here..."

03.10.2016

"..Today was a hard day for me as on the 3rd of october last year I was in the priory and I've not been discharged since so I was upset as I missed my nephew's birthday last year and I'm scared I'm going to miss it this year. I just feel like I've let myself and loads of people down..."

08.10.2016

"...as much as I hate my life I just want to get out and live my life the best I can ..."

18.10.2016

"...my cousens wedding is on Friday and I'm going to miss it and last year I was in Gallywood for my nephews birthday and this year I will be in the Christopher unit so I spent most of the day crying..."

21.10.2016

"...I've let everyone down by taking drugs & drinking I spent most of the day In my room crying I started head banging & [L] & [I/S] heard me from the office they ran down here and restrained me I was in floods of tears..."

23.10.2016

"...I just felt a bit down today so I wrote my will and I said I hope one day you can all find it in your hearts to forgive me and I put money in the will for [I/S] and my family I just can't go on..."

24.10.2016

"...I cried for most of the day sleeping is the only time I can escape my thoughts the staff just don't understand..."

26.10.2016

"... I had a really crap day. It was my review day but the Dr said he will see me on Friday so I was pissed off so I slammed the door and staff couldn't open it so I had to fight to see the Dr so that wasn't fair. I just want to get out hospital more then anything I just started shouting at the Dr and I said your getting investigated and you don't listen to what the patients want so I started crying and I walked out..."

27.10.2016

"...I couldn't go on my leave so I was really pissed off so I just stayed in my room and cryed for ages and then I got out of bed and banged my head loads of times on the floor ... they had to stop me I had a massive bump on my head ..."

31.10.2016

"...I punched the wall really hard and I had to go hospital to have an X Ray..."

10.11.2016

"...I had to go to the C&E centre...I really didn't want to go because I've been in hospital so long the outside is very scary ... I'm scared of getting hurt and I got paranoid everyone was staring at me I couldn't sit down I was shaking like mad but I went in..."

13.11.2016

"...this bank staff took me on my leave I was a bit scared because I didn't know him..."

19.11.2016

"...I ripped my sheet up and I put newspaper in the door to stop the staff from coming in so I went in my bathroom tied it really tight around my kneck. I just had enough I just wanted to end it ..."

23.11.2016

"...I wanted to get off my level 3s and I didn't. Nothing is moving forward at all so that is really pissing me off..."

02.12.2016

*"...a new male patient came in and I get really scared when male patients come in so I was shaking and I ran to my room but staff *** just calmed me down and said he's not going to hurt you I was like are you sure..."*

04.12.2016

"...Today I was so stressed out [I/S] wants to have sex with me and he kissed me on the lips and touched me. He just won't leave me alone...It made me so mad that I got out of my chair and the alarms get pulled for me I was crying for hours just sick of it I tried to attack him with the remote..."

05.12.2016

"...I was feeling really shit because of [I/S] likes me and it's getting to much with the things he is doing to me..."

07.12.2016

"...I had my review and Dr [I/S] was quite nice to me which is weard ...we went to the shop It was scary being out but I did OK..."

09.12.2016

"...[I/S] took me and [I/S] in the Female lounge and they said [I/S] I know you kissed Abbi and you are taking advantage of a vunrable patient. He denied it all even though staff saw him so I went to my room crying and I cryed on [L]'s shoulder saying move him to a different ward..."

13.12.2016

"...even though I was on obs and I gave back the cord that I had me [I/S] and [I/S] were on level 3's because we were trying to hang ourselves so I was really pissed off I only thought of it but I didn't act on it which is really good for me. The staff are fighting for me to come off obs..."

108. An extract from Abbi's blue / grey 'NOTES' notebook states:

14.12.2016

"...We had an agency staff on who didn't no what she was doing she said to me and [I/S] where is the toilet so me and [I/S] showed her then she pulled her alarm because we wouldn't go back through the staff member got in trouble..."

109. An extract from Abbi's multi-coloured fluffy diary, dated 18.12.2016 states that she went Christmas shopping with her mum for few hours and she was 'was very nervous and Anxious'.

110. Further extracts from Abbi's pink diary with butterflies state:

30.12.2016

"...I went to my room becuse I felt so sick and I was tieing loads of cords together and [L] came in and she calmed me down I couldn't stop crying..."

11.01.2017

"...the horrible Dr [I/S] wasn't in so my review is now on Friday so I am pissed off He dosen't no any of his patients but yet we have to wait all week to get what we want. That Dr dosen't give a shit about anyone but himself...when I came back i came to my room crying I ripped my bed sheets and tried to hang myself..."

13.01.2017

"...had my review had an argument with the Dr My leave still hasn't changed It's still 30 min...I swore at the Dr he does not understand anything at the end of the day staff and the Dr's go home ...we have to live here..."

17.01.2017

"...Today wasn't a good day for me I went on my leave ... got myself a bottle of vodca and a pac of fags. I drank my vodca in the park and got pissed. I shouldn't of done it but Iv'e missed my drink so much so one of the members of the public found me I passed out ... I woke up in hospital with all the securaty guards holding me down I went to the toilet and I had a blade so I sliced my throught and my arms..."

19.01.2017

"...Today was a really bad day for me I went on my leave ... bought a big bottle of vodca and a pack of fags ... I went somewhere quet and no one saw me and then I drank the whole bottle I was paraletic. I passed out in the park and then a member of the public rang the police and the ambulance. And I got taken to hospital. I kept on trying to punch and bite the staff but that wasn't me that was the vodca I had to be held down by loads of security guards and I had an injection in my arm..."

20.01.2017

"...I had a blade In my room so I sliced my kneck open...they put me on level 3's so I cryed my eyes out and I headbanged. Then I wanted a teddy in my room because it means a lot to me and [I/S] snached it off me. She made me worse..."

a) I want to explain that this teddy was Abbi's constant companion throughout not only admissions but through life. He was a security blanket in an unknown world. His name was Rocky and he was cremated beside her so they can be together forever.

111. Extracts from Abbi's pink diary with butterflies continue to state:

21.01.2017

"...I was crying so I trashed my room and I headbanged really hard..."

112. An extract from Abbi's red A4 folder states:

Day 5 Friday –

"...spent most of the day crying ...I wanted to get off my level 3's but the Dr thinks he knows best. I want a different Dr as he makes me feel worse. After my review I can to my room and screamed. I started to lash out and I hit my head..."

*"I'm so sorry mum ***and ****

*I've tried my best and I really can't go on anymore just know that I love you all so much and I love *** & ***...They are my world. Life has been really hard and I feel drained all I've ever wanted is to be happy but life has just been so shit and being in hospital has been so traumatising for me that I will never forget what happened to me when I was in there sorry for pushing you all away I just didn't want you to all see me with black eyes and scars so Just know love you all so much*

From Abbi x"

113. Further extracts from Abbi's pink diary with butterflies state:

23.01.2017

"...I saw the Dr...I said things still aren't moving forward so he is thinking of moving me to a different unit. It's not going to make every thing better..."

30.01.2017

"...I felt really shit so I ripped my bed sheet up and put paper under my door then I tied it really tightly around my kneck so I go given oxigen and [I/S] was on my level 3's..."

31.01.2017

"...Then staff pissed me off so I went to my room and broke down in tears. It's like staff want you to kick off..."

03.02.2017

"...are rooms got searched because someone had a blade so we had a massive meeting and the stupid Dr put the blades in front of us. It was such a trigger he really should of thought before he did that so we were all pissed off..."

05.02.2017

"...The night staff really piss people off. The night staff stay in the office all night and when it's time to go to bed. It takes one person to say bedtime and they all come marching out the office then all the staff stay down the corridoor. I was so pissed off it's like they want someone to kick off. I had a really shit night..."

07.02.2017

"...I'm glad someone I know and get on with took me...was so scary I go from having no leave to 4 hours..."

08.02.2017

"...they wouldn't let me have any leave today...because I was in a low mood. If I wanted to run off I woul'd of done it yesterday..."

09.02.2017

"...they talked to me for ages but I was in so much distress when they went I waited about 10 mins and then I banged my head really hard on the floor and [L] [I/S] and [I/S] came in and [L] got the Dr in to see my head because it had a massive lump..."

10.02.2017

"...we talked about when I first got admitted when I was 16 and how my dad was an alcoholic and [an individual] was abusive to me and 've had loads of shit in my life and then I talked about my school life ..."

12.02.2017

"...After I got told I can't leave I just went to my room and cried and screamed I just had enough with everything . So I banged my head..."

13.02.2017

"...Today I was feeling quite low with a lot of things I couldn't have my leave because staff were being awkward and making excuses so I spent most of the day crying in bed..."

114. An extract from Abbi's blue / grey 'NOTES' notebook states:

14.02.2017

"...Went to the C&E centre the steps group with bank staff and agency ... ran off..."

115. Further extracts from Abbi's pink diary with butterflies state:

14.02.2017

"... went to the steps group with a bank and a student ...went to pharmacy got a packet of parasetamol then I went to...pub...got a vodka..."

15.02.2017

"...I was already awake... I didn't sleep at all because I was out all night...I saw the Dr. He wanted to know what I did yesterday so I told him then I had an argument with him I said to him do you know how hard it is and I said you have never been through Mental Health and I walked out of my review I was so pissed off..."

22.02.2017

"...I wrote a letter saying I regret what I did and it shouldn't of happened ... I would like my leave back and I just want to move forward again. He didn't listen to anything I said so he didn't give me leave even though my mood had been fine it didn't make sense to me or staff I know that staff were pissed off with the outcome I just cried after that..."

116. An extract from Abbi's pink diary with butterflies states:

03.03.2017

"...Today was such a stressful day Me & [I/S] had to go to Hadleigh ward that is in Basildon because the ward is closing for the weekend My transport got here at 3:30 in the morning me... I went in a secure Ambulance..."

117. From recent review of the NHS website, it appears that Hadleigh Unit is part of EPUT, Basildon Mental Health Unit and is 'an intensive care ward'. As Abbi did not spend a very long on this unit, I was not able to view it and cannot provide any comments.

118. Extracts from Abbi's multi-coloured fluffy diary state:

03.03.2017

*"...Went on leave with ****

*I went to Mayflower ward to see ***but *** wouldn't let me. She said she will ring the ward if I visit *** So I got a bit pissed off so I went to the shops and bought loads of Chocolate ...*

*...he said we are closing the ward down for the weekend...Me and *** went to Hadleigh ward in Basildon so I had a few fags before I went there I was so stressed and scared ...and then off I went with *** and *** in a secure ambulance but I said to *** I'm not going in the cage I have had bad experiences with the cage"*

"...The whole place was a mess...I find it hard to sleep in a new place where you don't know anyone ...didn't sleep that well..."

04.03.2017

"...I rang my mum to tell her how shit this place is and how the staff are rude to you...

I sat in the corner of my room and cried my eyes out for ages and staff kept coming in and turning my light on so I said get out of my room and leave me alone but they wouldn't go I was so pissed off I head banged and I tried to get them out of my room and they pulled there alarm and waited outside for 10 minutes and they came in and staff said we have an injection for you so lie on the bed and I thought that I don't need an injection so I kicked off at them and they restrained me on the floor and gave me an injection..."

05.03.2017

"...[I/S] got given her meds but she was going to take them at the right time so she had one tablet in her pocket and the poor girl has just had surgery on her arm and she hates to be touched. I was fuming. All the staff restrained her on the floor. The staff had no reason to do that. I was just praying that ...was OK but they got off her...Her arm and legs must be in agony because of what they did....

...then I went to my room and I was feeling quite sad so I ripped my bedsheets up and tied it round my neck as tight as I could ...The staff don't really do there checks. The staff cut it off and they put me on a lot of oxygen ... when I tie a ligature I do it really tight. So they called an Ambulance and the Ambulance came and took me to hospital...

...I cant wait to go back to Christopher..."

119. Further extracts from Abbi's pink diary with butterflies state:

10.03.2017

"...patient called [I/S] wanted to start an argument. He like provoking people He really got me to the point where I nearly hit him I screamed and I had a bit of a cry. He is so creepy I don't like it he stares at you and smiles in such a horrible way I try & stay with staff..."

22.03.2017

"...a patient was kicking off in the comunal area and taking staffs time. Me & [I/S] sat down the corridoor and the fire door was open so me & [I/S] hid from the staff..."

27.03.2017

"...because I felt shit yesterday I'm not allowed my leave so I was pissed off I felt shit If I show any emotion like if I'm sad or angry I just get told off...After dinner I went to my room screamed and then cried...I wanted to head bang a wall really hard but I didn't..."

02.04.2017

"...I was in a really shit mood I said to the staff stick to the rules don't change them when you feel like it because it pisses everyone off I was pissed of with everything and everyone the staff were annoying me...so I cried and I said I just wanted to go to my room & sleep The staff were making me worse..."

04.04.2017

"...had my phycoligist session I was feeling low so I talked to her about a few things and I couldn't go on my leave today because I was angry and sad it feels like I'm being punished for having emotions it made me even more pissed off hat I couldn't go out I trashed my room through my bed on the floor the I banged my head only a couple of times..."

26.04.2017

"...but I spoke to [I/S] about my leave and how unfair it is. It feels like they don't want me to move forward they just want me locked away in here ... went to my room slammed the door trashed my room screamed cried I was so upset and angry the staff just love making you feel shit I lyed on my floor headbanged the floor a few times ... I said to [I/S] I'm trying my hardest what else do you want me to do..."

28.04.2017

"...when the night staff came on they said they need to lock the female lounge during supper that has never been a rule staff were delebritly winding me up they like making people sad in the end I cried & said open the door I screamed..."

30.04.2027

"...I try and isolate myself away from the staff because they make you worse why do staff get a kick out of making people cry...I just want the staff to be honest about things I can't trust ... I came to my room and headbanged I didn't want them to hear it I was just so sad and angry if I ever had a bleeding on the brain from all the headbanging I do blame some of the staff for making me so upset..."

17.05.2017

"...I just want to get out of hospital and get on with my life but I feel like no one wants me to That is why I was sad..."

24.05.2017

"...asked the Dr if I can have unorscorted ... but as always the answer is no. I walked out and said there is no point your not going to give me anything no matter how much I'm trying so I walked out called him a twat then I went to my room and screamed. I am so pissed off..."

30.05.2017

"...me and [I/S] are the only girls but [I/S] is much older than me I feel so uncomfortable with all the men around I get a bit scared. It's not nice..."

02.06.2017

"...Dr brought up things that are in my past thing that happend none of it needed to be brought up then he said can I see your burns on your arm this was in front of all the people at my CPA it wasn't on..."

04.06.2017

"...I sat on my widow ledge watching the world go by with m curtains shut it's where I go when I want to get away from staff..."

05.06.2017

"...my mum rang she is trying to do something to get me out as I'm not moving forward here. It's been in the paper so many times about all the deaths in the Linden centre..."

07.06.2017

"...saw the Dr...but as always he was making me so angry so I said about my birthday leave and it's like talking to a brick wall ...so I found a brick outside so I put it in my pocket...I was smashing my head with the brick I had blood on my face and in my hair..."

120. An extract from Abbi's blue / grey 'NOTES' notebook states:

09.06.2017

"...I banged my head I had to go to A&E and have a head scan..."

121. An extract from Abbi's pink diary with butterflies states:

09.06.2017

"...the ward was really unsettled everyone was kicking off I held it together as much as I could but it just got to much so I went to my room screamed and I started headbanging... I was so upset I banged my head on the floor and trashed my room and there was loads of blood on the floor... and I had to go to AnE I was going to have a head scan but in the end it was fine..."

122. Further extracts from Abbi's multi-coloured fluffy diary states:

15.06.2017

"...celebrated my birthday... Today was such a good day..." Abbi went to town with her mum.
*"...I got an I phone 6... I got a Fathers day card for ***..."*

18.06.2017

"...this 60 year old man punched me really hard I tried to hit him back my mouth was bleeding so much I was shaken up..."

19.06.2017

"...was scared to leave my room but he was on level 3s My lips are out here and my bottom lip is purple and bruised I slept on a beanbag in my room I've got stuff with me just for support and to make sure he stays away from me ...The police will have to interview and I am pressing charges"

*"...I was on level 3's for my safety ...***helped me call the police I was shaking ..."*

123. An extract from Abbi's pink diary with butterflies states:

20.06.2017

“...[I/S] helped me call the police I was shaking...I was crying my eyes out so [I/S] helped me speak to them...I was so upset I banged my head on the wall...”

Cygnnet hospital

124. According to Dr [C]'s statement this admission was from **21 June 2017 – October 2019** and she was transferred here from Christopher Unit. Dr [C]'s statement states “...28. On the 21 June 2017 Miss Smith was transferred to the Cygnnet Hospital. This was a 2- year **rehabilitation admission.**” (emphasis added).

125. I visited Abbi at Cygnnet on numerous occasions, usually to pick her up and take her out somewhere, or to bring her home for some home leave. I never got further than the reception waiting area and so cannot comment on the ward environment. I never got to see this ward myself.

126. I believe that there were some activities available here. I remember Abbi talking about visits, and occupational therapy support on this ward. I remember that there was a park over the road that Abbi would go into a lot. I do not recall any outdoor space other than the park. Usually when I visited Abbi we went out somewhere - to the shops to buy her things, to a cinema, for a meal - we never stayed within the grounds of the unit.

127. I remember Abbi wanting to come for home leave sometimes and the staff insisting she would have to catch the train, or the bus by herself - and I remember trying to organise this in terms of asking her to get one of the other patients to put her on a specific bus that I knew terminated where I worked, so that she would not get lost. I remember at other times they would send her home in a taxi and have her picked up again via taxi. At this stage Abbi was around 23 years old.

128. Extracts from Abbi's multi-coloured fluffy diary state:

06.11.2018

“Today I got the train to Colchester ...t's the first time I have ever got the train on my own I was a bit scared but I did it. I was really happy with myself...”

****put me on the train then she left and on the train I saw *** from my old unit the St Aubyndy centre I was shocked to see that women. She was horrible. One time I remember she threw me on the floor sat on my back and injected me. I just wanted to shout at her and tell her how she made me feel. To calm me down I put my head phones in and I listened to my music. When I got there *** was waiting for me at the station...*

*...me and ***...to see the fireworks...I love fireworks...I am still shocked that I got the train on my own...”*

06.12.2018

“...Today I got the train...she put me on the right train. It only took 28 minutes so it was a quick journey...Mum met me at the station on platform 8. It was a bit scary getting the train but I did it...it was so nice being at home...”

129. Abbi was at Cygnnet too long and became institutionalised (also given the length of time she had already spent at other units). I believe Cygnnet questioned her diagnosis of autism (as the St Aubyndy Centre had done). When they discharged her, it was into inappropriate accommodation, as it was solely to support people with mental health recovery (by giving them a stepping stone to an independent tenancy). Abbi was only ever supposed to be in this tenancy for two years, at which point she was supposed to miraculously be able to live an independent life. I would like to bring to

the Inquiry's attention an Occupational Therapy Discharge Report from August 2015 which indicates that it was not so easy for Abbi to live independently. The report states:

"...Current situation: Abbigail currently lives at home with her Mum....

*Overall, the results of the AMPS assessment suggests that Abbigail would not require support to live in the community. However, it is my professional opinion that Abbigail does require assistance to live independently and she **currently received a great deal of support from her mum**. Should Abbigail live in an environment **without her mum** in the future her level of support needs would very likely increase. This is mainly in relation to managing her anxiety, maintaining her mental health and the risks to herself and managing relationships with others..."*
[emphasis added]

130. There were lots of times when Abbi came home and we would need to immediately give her clean clothes and wash the clothes she had come out in. We would also encourage her to bathe whilst with us. During these periods I noted that all her underwear can only be described as revolting, to the point of disintegration. I offered to buy her more, but she declined. There were also occasions when her bodily odour was so bad that we needed to travel home with the car windows open.
131. It was also at Cygnet that Abbi was able to abscond, several times as far as I am aware. On one occasion I remember calling the police to ask what was happening, and they were shocked to discover from me that she had a diagnosis of autism. The police said that the unit had not shared this information with them and that they needed to therefore treat the report differently (than they were doing from the report that Cygnet Beckton had provided). I can remember I spoke to a female police officer and she sounded really concerned. I remember her checking with me whether Abbi had an actual diagnosis (as if she didn't believe me) and when I replied that she did, the police officer seemed very flustered by this.
132. Cygnet, to their credit, did invite me to all CPAs. I tried to attend those I could, despite working full time. On one occasion I remember being the Outpatient Clinic Coordinator for a large London Hospital and only being able to attend the CPA meeting by sitting in my car - as I could then join the CPA by phone call. I remember that the Cygnet clinician was so rude, abrupt and condescending towards me. I tried very hard to highlight Abbi's patient journey so far and the downward spiral she was experiencing. I asked how her autism was being taken into account, at which point the clinician laughed at me and told me he was going to rescind her diagnosis of autism and that he didn't believe it. I can remember sitting in my car crying uncontrollably at the offhand attitude he had displayed with regards to Abbi's diagnosis and I have no idea if he did somehow manage to rescind it. From that point I stopped feeling as though I could contribute or help Abbi in any meaningful way. I believe I stopped attending and said that I simply wanted to be her mum. Oh, how I bitterly regret not attending and wish that I could rewind the clock with the knowledge I have now.
133. Dr **A**'s Addendum Psychiatric report dated 16 June 2025, entitled "Report for the Inquest" highlights the following worrying concerns with regards to Abbi's care in **Cygnet** (New Dawn Ward):
- "...1.10. This addendum report is prepared at the request of His Majesty's Coroner Sonia Hayes, HM Area Coroner, Essex Coroners Court, Essex Coroner's Service, Seax House, Victoria Road South, CHELMSFORD, Essex, CM1 1QH, and within the updating e-mail letters of instruction, dated 16 April 2025 and 6 June 2025, I have been requested to produce an addendum independent report in relation to Abbigail Louise Smith (henceforth referred to as Abbigail Smith) '... for anything pertinent to Cygnet and how this may have impacted on Abbigail and was potentially contributory or causative of her death'...."*
- "...4.2. Within a Psychology Report prepared by **[I/S]** (Clinical Psychologist), dated 30 August 2017, it is noted:*

'Circumstances Leading to Admission

4.2.1. Ms Smith is a 22 year old Caucasian female with a diagnosis of **Emotionally Unstable Personality Disorder**, Borderline Type F60.3 (ICD-10). Prior to admission to New Dawn Ward in Cygnet Hospital Beckton, she had been in the Christopher Unit, a PICU ward in the **Linden Centre**. It was felt by Ms Smith's **most recent care providers** that a **specialist Personality Disorder unit** could be an appropriate service for Ms Smith in her recovery. Having been assessed and deemed eligible for transfer to New Dawn Ward, a **Tier 4 Personality Disorder Service**, the purpose of this admission would include for Ms Smith to be assessed for Dialectical Behavioural Therapy (DBT), which is a NICE recommended treatment for individuals with a diagnosis of Borderline Personality Disorder. The proposed initial treatment plan for Ms Smith includes assessment by medical staff (psychiatrists, nurses), psychology staff, occupational therapists, and drug & alcohol staff attached to the psychology department. Assessments would be with the aim of developing care plans within the initial weeks, focussing on her physical health, problem behaviours, gaining insight, making feasible plans for the future, life skills and relationships. Ms Smith would also be immediately able to access the DBT groups and would be allocated a 1:1 DBT therapist. The longer term care pathway aims for Ms Smith to work on acquiring skills to regulate emotions and learn effective coping strategies over the course of her admission. Ms Smith agreed to this admission and was subject to Section 3 (MHA 1983) when she entered New Dawn Ward..." (emphasis added)

"...4.2.2. There is no report of abnormal developmental milestones and no report of childhood sexual abuse. She explains that she was diagnosed with autism at the age of 10 at school but this is unclear and we do not as yet have any information to substantiate this diagnosis. Ms Smith did not like school and "hated everything about it". She left school prior to GCSE's due to her first hospital admission being when she was 16 years old..."

"...4.16. Within the Statement for the Coroner prepared by Dr [P] (Consultant Psychiatrist & Medical Director), dated 15 October 2024 and with regard to the care afforded to Abigail Smith during her admission to New Dawn Ward, Cygnet Hospital Beckton from 21 June 2017 – 7 October 2019, the following is noted:

4.16.1 **'New Dawn Ward at Cygnet Hospital Beckton is a tertiary level, specialist, inpatient therapy unit. It is commissioned by NHS England (NHSE) for the treatment of personality disorder.** New Dawn Ward receives national referrals from NHS Trusts'.

4.16.2 'Admitted patients are invariably individuals who, (a) pose an extremely significant and imminent life-threatening risk to themselves through Deliberate self-harm (DSH) and suicide, and (b) cannot be safely or effectively managed at Secondary Care level. DSH is also sometimes referred to as Non-suicidal self-injury (NSSI). Secondary Care provision predominantly comprises that delivered by a Community Mental Health Team (CMHT) and local General Adult Acute inpatient unit, or occasionally a Psychiatric Intensive Care Unit (PICU), and allied acute medical services (e.g. Accident & Emergency, A&E).

14.16.3 Abigail was referred to New Dawn Ward at Cygnet Hospital Beckton **by Essex Partnership University NHS Foundation Trust (EPUT)** specifically for the treatment of EUPD and associated suicide attempts and significant DSH. Funding had been approved by NHSE..." (emphasis added)

134. The report discusses in some detail the care which Abbi received. However, what I would like to bring to the Inquiry's attention is Dr [A]'s opinion on this care. Dr [A] states:

"...5.2. It should be noted that, throughout the following opinion, I have made reference to relevant guidance and clinical recommendations that both pre- and post-date Abbigail Smith's admission to Cygnet Hospital Beckton and her further admission to the Linden Centre; I include these documents both to set out good practice but also in light of the fact that their basis is pre-existing research and clinical consensus and – thus – information that should have been available to services and clinicians at the time.

5.3. Within the earlier report (Ref: SMITH-12172), a number of findings were set out in relation to Abbigail Smith's care and diagnostic history. However, specific aspects of the care she received at Cygnet Hospital Beckton warranted further clarification, given their clinical, procedural and systemic implications; these include the processes by which Cygnet staff engaged with her existing autism diagnosis; the rationale and methodology through which psychiatric diagnoses, most notably Emotionally Unstable Personality Disorder and Simple Schizophrenia, were added or removed; the nature of therapeutic interventions offered in light of these diagnostic conclusions; the degree to which any prior formulation was relevant to the matter of safety planning; and the communication of these issues between Cygnet Healthcare and Essex Partnership University NHS Foundation Trust (henceforth referred to as 'the Trust').

*5.4 At the **point of admission**, the available information confirms that Abbigail Smith was afforded diagnoses of Autism Spectrum Disorder (ASD), Emotionally Unstable Personality Disorder (EUPD) and Recurrent Depressive Disorder.*

5.4.1. The diagnosis of ASD was supported by a 2005 Speech and Language Therapy report and a further structured assessment undertaken in 2011 using the Autism Diagnostic Observation Schedule (ADOS), both of which are included in Abbigail Smith's clinical records.

5.4.2. The diagnosis of EUPD appears to have been applied and maintained within previous community and in-patient settings and was referenced within Abbigail Smith's referral to Cygnet Hospital Beckton.

5.4.3. The diagnosis of Recurrent Depressive Disorder is also noted within Abbigail Smith's historic psychiatric records and aligns with contemporaneous prescribing of antidepressant medication and her documented episodes of low mood, anergia and suicidal ideation. The subsequent documentation and psychological formulation, coupled with the defined purpose of the service, confirms that the diagnosis of EUPD was central to the referral process and the clinical reasoning that informed her admission to Cygnet Hospital Beckton

*5.4.4. **There is no evidence that, aside from a passing reference, the diagnosis of ASD was incorporated into the initial formulation or treatment planning at Cygnet Hospital Beckton, despite its clear documentation within her clinical history; there is, further, no evidence of any critique as the degree to which Abbigail Smith's presentation should be ascribed to a Disorder of Adult Personality or to a Neurodevelopmental Disorder.***

5.5 Relevance of Diagnosis of Autism Spectrum Disorder

On the basis of a pre-existing diagnosis of ASD, Abbigail Smith should have been provided with relevant reasonable adjustments to her care and treatment on the basis of the anticipatory duties placed on public sector bodies under the Equality Act (2010).

5.6 On the basis of a pre-existing diagnosis of ASD, Abbigail Smith should further have been entitled to a Care and Treatment Review (CTR) under NHS England's Care (Education) and

Treatment Review policy (2017, updated in 2023), which applies to autistic people and those with a learning disability admitted to specialist inpatient mental health settings; this meeting should have occurred at, or immediately after, her admission to hospital and at regular points thereafter.

5.7 CTRs are designed to provide structured oversight, ensure person-centred care and reduce unnecessary restrictive inpatient placements; there is no evidence that a CTR was considered or conducted, nor that external scrutiny was sought during her prolonged admission. This omission undermines both the clinical governance and legal safeguards designed to protect people like Abbigail Smith from diagnostic exclusion and institutional drift; the onus for arranging a CTR would have fallen to both the commissioning Integrated Care Board and the admitting hospital.

5.8 I am concerned to note that, whilst briefly referenced at the point of admission, the diagnosis of ASD was largely ignored throughout the duration of her admission; I further note that, despite confirmation of the diagnosis been received from [I/S] this did not alter the psychological formulation, the care planning or the treatment afforded to Abbigail Smith and that the focus remained upon EUPD.

5.9. The decision to disregard the existing diagnosis of ASD, on the basis of what appears to have been described in the records as a lack of “clinical consensus,” was neither consistent with established NICE guidance (CG142: Autism in Adults) nor reflective of recognised good clinical practice; this decision was not accompanied by the use of validated diagnostic tools, the undertaking of a structured re-assessment or any documented multidisciplinary diagnostic review.

*5.10. Whilst post-dating Abbigail Smith’s admission to Cygnet Hospital Beckton, the current NHS England National framework and operational guidance for autism assessment services (April 2023) and the NHS England Dynamic support register and Care (Education) and Treatment Review policy and guide (January 2023) reiterate, reinforce and collectively summarise the existing and accepted clinical best practice (to include NICE guidelines) and **clearly set out that the removal of an autism diagnosis should only occur through a process as robust and comprehensive as that required for its initial establishment.***

5.11. This includes a full re-assessment using standardised tools such as ADOS and ADI-R, review of developmental history, input from a multidisciplinary team with relevant expertise and triangulation with collateral information from family and educational records. The guidance further warns against the inappropriate retraction of autism diagnoses on the basis of non-engagement or clinical disagreement in the absence of such structured review.

5.12. The rationale provided by Cygnet Hospital Beckton, which cited an apparent lack of observed symptoms or consensus within the team as justification for disregarding the diagnosis, does not meet these standards. There is no indication that an autism-informed re-assessment process was followed, nor that a second opinion or formal diagnostic panel was convened. Moreover, no consideration appears to have been given to the risk of diagnostic overshadowing or to the known phenomenon of camouflaging and masking in autistic females, features increasingly recognised in both NICE and NHSE policy documents as leading to under-diagnosis and misdiagnosis.

5.13. There is also no indication that the team gave structured consideration to the extent to which Abbigail Smith’s known autism (and the manifestation of the same) may have influenced her presentation or impacted on her engagement with therapeutic input, to include communication differences, interpersonal functioning, emotional dysregulation and risk

behaviours; both NICE CG142 and NHS England's 2023 guidance stress the importance of identifying and making reasonable adjustments for autistic individuals and embedding these considerations across formulation, treatment planning and safety management.

5.14. In my opinion, the failure to do so in Abbigail Smith's case, despite long-standing and documented evidence of autism, represents a significant clinical omission.

5.15. Relevance of Diagnosis of EUPD

The diagnosis of EUPD was present at the point of admission and was central to the rationale for Abbigail Smith's referral to a Tier 4 Personality Disorder Service.

5.16. However – and as noted within Section 10.2.10 of the previously submitted report – 'there is no evidence of any validated assessment for Disorders of Adult Personality within the provided records or any evidence that consideration was given to her existing diagnoses of Autism Spectrum Disorder (ASD) and her borderline Learning Disability when a diagnosis of a Disorder of Adult Personality was being considered'.

5.17. I am surprised that a 'specialist' Personality Disorder Service did not undertake a structured and validated personality disorder assessment process (such as use of the Structured Clinical Interview for DSM Disorders (SCID-5-PD)) at or following the point of admission.

5.18. I am similarly surprised that the diagnosis of EUPD was apparently also then removed without any documented multidisciplinary discussion or similar structured re-evaluation and without a re-appraisal of differential diagnoses; the decision appears to have been made on the basis of observed disengagement and subjective clinician judgment rather than a formal diagnostic revision process

5.19. With regard to the totality of Abbigail Smith's admission to Cygnet Hospital Beckton, there also appears to have been no re-evaluation as to her original presentation in light of the determination of an absence of EUPD, particularly given the heavy reliance upon such a diagnosis to 'explain' Abbigail Smith's difficulties in communication, interpersonal relationships and emotional regulation and dysregulation; I note the original psychological formulation and would similarly make a number of observations in light of the removal of the EUPD diagnosis:

5.19.1. The psychological formulation set out in Section 4.2 above (and reiterated within latter iterations and CPA documentation) relies on a standard application of the Dialectical Behaviour Therapy (DBT) model for EUPD, referencing a biosocial model of emotional dysregulation; while this model may be appropriate for individuals with a confirmed diagnosis of EUPD, its application in the case of Abbigail Smith appears to lack critical scrutiny in light of her confirmed diagnosis of ASD.

5.19.2. The formulation asserts that Abbigail Smith's difficulties are rooted in a transactional model between biological vulnerability and an invalidating environment. However, there is no documented consideration of the alternative and – arguably more consistent – explanation that **her affective instability, interpersonal difficulties and atypical coping strategies arose not from a disordered personality structure but from her underlying autism compounded by repeated trauma and the effects of repeated hospitalisation in environments that did not meet her needs.**

5.19.3 There is no evidence within the psychological report that structured consideration was given to the core features of autism, such as impaired social communication, sensory sensitivities or executive dysfunction, all of which are known to contribute to emotional

dysregulation in autistic individuals; nor is there any reference to known constructs such as alexithymia or autistic monotropism, both of which were evidenced in Abbigail Smith's clinical presentation and are strongly associated with increased vulnerability to affective dysregulation and suicidality in autistic females. I would further note that the clinical team identified that she presented with alexithymia as a barrier to engagement in psychological therapies but that this was not linked to her ASD diagnosis.

5.19.4. Furthermore, the formulation did not reference or account for gender-specific phenotypic differences in autism or the clear evidence that autistic females often present with superficially intact social functioning due to masking and camouflaging and that such adaptive strategies can lead to diagnostic overshadowing and misattribution of behaviours to personality disorder rather than a neurodevelopmental origin.

5.19.5. The psychological report also lacks reference to Abbigail Smith's significant trauma history and does not appear to consider how complex trauma and institutional neglect might present as emotional instability and interpersonal conflict in an autistic woman. Instead, the formulation defaults to an EUPD conceptualisation that, in my opinion, fails to incorporate alternative formulations supported by contemporary research, including the likelihood of a complex PTSD phenotype and emotional dysregulation secondary to prolonged distress and unmet neurodevelopmental needs.

5.19.6. Overall – and viewed through a narrow lens of EUPD (and I understand that this can occur within specialist services that arguably have a focus upon the manifestation and treatment of a single disorder/diagnosis) – it remains that the formulation was broadly unchanged throughout Abbigail Smith's admission and could be considered as being diagnostically reductive.

5.19.7. The formulation failed to incorporate autism-specific considerations, relied uncritically on a DBT framework designed for personality disorder and did not demonstrate the necessary multidisciplinary input or diagnostic flexibility required by both NICE (CG142) and NHS England's autism assessment guidance (2023); crucially, there is no provided evidence to suggest that the service sought to give an alternative formulation that would have had longer-term benefit for Abbigail Smith and would have contributed to a more detailed and comprehensive understanding as to her risks and longer-term safety planning.

5.20. In terms of the diagnosis of EUPD in the context of discharge – and regardless of the robustness of the assessment process – I would also note the clear absence of the diagnosis on the discharge summary; thus, questions need to be asked of the Trust as to why the records and the clinicians continued to rely upon an EUPD diagnosis up to – and including – Abbigail Smith's admission to – and discharge from – the Linden Centre.

5.21. Relevance of Diagnosis of Simple Schizophrenia

According to ICD-10 (World Health Organization, 1992), the diagnostic criteria for Simple Schizophrenia (F20.6) require a progressive development over at least 1 year of negative symptoms such as:

- ✚ Marked apathy.
- ✚ Gradual loss of volition (avolition).
- ✚ Blunting of affect.
- ✚ Social withdrawal.
- ✚ Decline in performance at work or in education.
- ✚ Importantly, these symptoms must emerge without the presence of prominent positive symptoms, such as delusions or hallucinations.

5.22. In reviewing the clinical records – and whilst I accept that I did not meet with or have oversight of Abbigail Smith's care during this period – in my opinion, there is limited objective evidence to support the conclusion that these criteria were met with the required temporal consistency, symptom profile and – crucially – the exclusion of alternative explanations.

5.23 The application of the diagnosis of Simple Schizophrenia appears to have been primarily retrospective, introduced after the discontinuation of a prior diagnosis (EUPD) and the apparent observation of reduced self-injurious behaviour and increased social withdrawal in the context of a trial of CLOZAPINE.

5.24. There is, however, no documented evidence of a structured longitudinal assessment that would support the insidious progression of negative symptoms over a year or more as required by ICD-10.

5.25. I would additionally note that several of the features described in support of the schizophrenia diagnosis, such as reduced affect, apparent emotional blunting and withdrawal, can also be accounted for by established aspects of ASD. In particular, autistic individuals may present with social and communicative withdrawal due to sensory overload or demand avoidance; similarly, alexithymia (recognised as being present), flattened affect and executive dysfunction may manifest in ways that resemble the negative symptoms of schizophrenia, particularly when viewed outside the context of a neurodevelopmental framework.

5.26. The overlap between these clinical features demands a cautious and structured differential diagnostic approach, especially in a case where a confirmed diagnosis of ASD already existed and had not been formally rescinded, but there is no indication that any such structured differential assessment occurred, nor that the diagnostic team robustly considered the possibility of autistic burnout or trauma-induced withdrawal states; these phenomena are increasingly recognised within autism research and would offer an alternative explanation for Abbigail Smith's clinical presentation without the introduction of an additional diagnosis.

5.27. With regard to pharmacological treatment, the apparent clinical improvement following the initiation of CLOZAPINE appears to have been used as post hoc justification for the schizophrenia diagnosis; this may be an unduly harsh assumption and – thus – would benefit from critical comment from a relevant representative such as Dr P

5.28. It should be recognised that CLOZAPINE is an atypical antipsychotic with an extremely broad receptor profile, to include effects on serotonergic, dopaminergic and adrenergic pathways; in autistic individuals, improvements following CLOZAPINE may reflect modulation of treatment-resistant anxiety, reduction of hyperarousal (particularly in an environment that is creating unmanageable sensory and other 'demand') or sedation, thus not evidence of schizophrenia per se.

5.29. It should also be noted that there is a small, but emerging, body of literature suggesting that low-dose atypical antipsychotics, to include CLOZAPINE, may be beneficial in highly aroused or dysregulated autistic individuals due to these mechanisms, independent of psychotic illness.

5.30. In Abbigail Smith's case, there is no evidence that the reduction in self-harm or increased behavioural compliance following CLOZAPINE was critically examined in terms of alternative explanations; from the provided documentation, I cannot identify that any structured assessment of psychosis was undertaken at the time the diagnosis was applied.

5.31. ***In my opinion – and on the basis of the information provided to date – the application of a diagnosis of Simple Schizophrenia in this case was inadequately justified and insufficiently robust.***

5.32. *This does not wholly discount the diagnosis (hence the suggestion of critical comment from Cygnet Healthcare should they be called to the inquest) but the service potentially failed to exclude neurodevelopmental and trauma-related differentials and risked mischaracterising the longer-term trajectory of Abbigail Smith's mental health; **the consequences of this mis-diagnosis included a missed opportunity for autism-adapted therapeutic intervention and contributed to a continuation of care that did not reflect her primary needs.***

5.33. *Overall, the clinical approach to Abbigail Smith's diagnosis and care at Cygnet Hospital Beckton included failures to adhere to accepted standards of diagnostic assessment and formulation, a failure to recognise and incorporate her confirmed diagnosis of ASD and a lack of diagnostic consistency or scrutiny in the application and removal of major psychiatric labels; despite clear documentation of autism in her clinical history and corroboration from external sources, the diagnosis was not integrated into her care, nor were appropriate adjustments made as required under national policy and equality legislation.*

5.34. ***The sequential removal of the diagnosis of EUPD and the application of a diagnosis of Simple Schizophrenia both apparently occurred without structured, validated assessments or multidisciplinary diagnostic review and failed to reflect a comprehensive understanding of Abbigail Smith's underlying neurodevelopmental needs.***

5.35. *In effect, Abbigail's presentation, marked by affective dysregulation, interpersonal difficulties and disengagement, was repeatedly interpreted through a narrow lens that omitted her autism. This led to treatment strategies, such as standard DBT and CLOZAPINE, which may have been ill-suited to her needs and which did not meaningfully improve her longer-term outcomes; I have already noted the alternative hypothesis as to the stabilising effect of CLOZAPINE having reflected its impact on anxiety and arousal rather than confirming a psychotic process.*

5.36. *In the context of the removal of the EUPD diagnosis, there is no evidence of a comprehensive review of Abbigail Smith's formulation that drew together her autism, trauma history, psychosocial context and behavioural responses in a cohesive, co-produced or person-centred manner.*

5.37. ***I would further reiterate that, following discharge, the Trust continued to rely upon the diagnosis of EUPD; thus, Abbigail Smith's interactions with services continued to be coloured in a manner that undoubtedly negatively impacted upon her treatment pathway...."***

(emphasis added)

135. An extract from Abbi's pink diary with butterflies states:

21.06.2017

"...Today was the day I was going to cygnet..."

136. An extract from Abbi's blue / grey 'NOTES' notebook states:

26.06.2017

"...I said to the Dr ...been in the system 6 years I just want to get out..."

137. Further extracts from Abbi's pink diary with butterflies on state:

26.06.2017

"...I said to the Dr... I've been moving place to place I just want to get out I've done my time These places make you worse and I will probably need therapy because of what the staff have done to me..."

29.06.2017

"...I went on facebook and I nearly cried. My mum put on loads of things of how horrible I got treated in hospital and me and mum want to share the story so the staff don't hurt anyone else I need more therapy for what the staff have done to me I will never forget what they have done. It will haunt me for a long time..."

05.07.2017

"...my solicitor came to see me. I told her what has been going on and how I was assaulted and the police arnt doing anything. She was shocked..."

07.07.2017

"...I was in the bath and my sponge got caught in my nail and It started to unthread so I got out the bath went to my room and said I coul'd use this as a ligiture but then I said to myself I don't need this anymore and I put It in the bin. About 2 years ago It woul'd never of crossed my mind to put It in the bin but I did It which Is a huge thing for me so I cried...I was happy that I put It in the bin..."

24.07.2017

"...I've finally got unascorted leave I really hope this time I'm not going to mess it up and I've got 6 hours with my mum when she comes down..."

28.07.2017

"...tied the laces round my kneck as tightly as I could..."

138. An extract from Abbi's multi-coloured fluffy diary states:

01.09.2017

*"...Today I had two overnights. So I went home on Friday...It was such a nice day...The next day was ***s Barmitzva...it was a lovely service...For once in my life I felt really good about myself..."*

139. An extract from Abbi's blue / grey 'NOTES' notebook states:

12.09.2017

"...suicide attempt needed CPR..."

140. An extract from Abbi's multi-coloured fluffy diary states:

01.10.2017

*"...Today was a stressful day I woke up for a planning meeting then *** rang me I haven't spoken to her in ages So I spent all day trying to ring her back but it was a nightmare to get through...
...I told her about my major incident and how I needed CPR..."*

141. An extract from Abbi's blue / grey 'NOTES' notebook states:

04.04.2018

"...ran away and got a bottle of vodka had my bank card and ID I drank half a bottle then passed out smoked weed with these boys..."

142. An extract from Abbi's multi-coloured fluffy diary states:

29.07.2018

*"Mums and ***'s wedding... It was so nice seeing everyone... It's so nice seeing my mum so happy..."*

143. Extracts from Abbi's blue / grey 'NOTES' notebook state:

21.08.2018

Ward wound by Dr P *"...I asked for informal/ He said I'm close to getting out..."*

01.10.2018

"...ward round i got informal..."

144. An extract from Abbi's multi-coloured fluffy diary state:

22.12.2018

"...It was so nice being home for Christmas. I'm going back on the 27th..."

145. An extract from Abbi's black 'keep making magic' notebook states:

04.01.2019

"...she told me my dad passed away in his sleep yesterday...It should have been me not him...started to head bang..."

146. An extract from Abbi's blue / grey 'NOTES' notebook states:

13.01.2019

"...havn't eaten in 8 days and I fainted..."

147. Extracts from Abbi's composition notebook state:

25.01.2019

*"...I cried and I said to *** can I go to my mums and he said if you do that he will put on a section. It's not fair I havn't done anything wrong..."*

29.01.2019

"...I got a black dress black tights and black boots for my dad's funeral..."

148. Further extracts from Abbi's black 'keep making magic' notebook state:

01.02.2019

"...Dad's funeral..."

07.02.2019

"...got kicked out my room 8 til 8. There isn't a reason for it so I cried ...staff never came to see if I was alright they just left me. ...I said I'm informal and a fag would help me. He didn't listen at all he just said you can go at 3:30. He made me worse for not letting me got out so I started crying again and I screamed and slammed the door I was in so much distress but they don't care. At last I went out at 3:30 but it was with two staff. The next day a solicitor came...I told him everything he was shocked. It's also illegal to be locked out my room and to go out with staff because I'm informal ...It feels like I'm section..."

21.02.2019

*"...My solicitor came and I told her what's been happening. She wrote it all down. I said about ***threatened me with a section because I wanted to go to my mums this was on the 25th January 2019. Then on the 19th Feb I had to wait to go out. I waited about an hour. Then on the 20th Feb had to wait again to go out I waited 45 minutes. I'm informal so I should be allowed out when I want so my solicitor said you can get a claim off the staff because of how there treating you and an apology. If they do not do this it could go to court so my solicitor is going to write a letter to the hospital...The Dr treats other patients fine It's just me..."*

149. Further extracts from Abbi's composition notebook states:

27.02.2019

*"...Had my ward round and I've got 15 mins to car park even though I'm informal. It's out of order what they are doing. And I wanted to go to my mums for two nights but he said no. I have no idea why so *** rang my mum and sorted it out. Why is the Dr treating me like this. I spoke to *** my solicitor and she was shocked at the Dr for treating me like this..."*

04.03.2019

"...Had ward round and he gave me 45 mins to park. He's being out of order I haven't done any thing. He didn't give me a valid reason to why he is doing this..."

17.03.2019

*"...I was feeling so shit *** gave me a one to one and he was so nice..."*

18.03.2019

"...Head banged I can't do this any more..."

08.04.2019

*"...OT spoke to me about the crash and I just burst out crying. I feel so drained I'm better off dead...I've just had enough of life. I went to my room locked the door and head banged really hard and *** came in..."*

150. Extracts from Abbi's multi-coloured fluffy diary states:

05.04.2019

*"...***took me to the 173 bus and walked me there and put me on the right bus It was so nice of her so I got the 173 bus from...to...where my mum works. It was so much easier getting the bus then a train ...*

I talked to my mum about my hair falling out. As she looked over at me we crashed the car into another car. I felt so bad because it was my fault. The car is totally wrecked I said to my mum im so sorry I just wanted to go back to the Unit I felt so bad..."

08.04.2019

"...I feel so drained I'm better off dead' 'I've just had enough of life. I went to my room locked the door and head banged really hard..."

20.06.2019

"...It's 4 days at my mums ...It's the longest time I have had at home It was so nice being with family..."

On Sunday was my 24th birthday... I feel so lucky I didn't want people wasting there money on me It's so nice I love all my Cygnit girls..."

151. Extracts from Abbi's composition notebook state:

12.07.2019

"...Today has been such a big day for me I went to visit a placement in Braintree and I wasn't expecting it to be that good but it was so nice cant wait for the day that I move in and try to put hospital life behind me. I'm going to have blips but I feel like Im so much stronger to deal with them so can't wait..."

02.09.2019

"...Went to my new flat...mum and sister helped me unpack a few things..."

16.09.2019

"...went to my flat for the night...My sis has been a huge help staying the night has been good but also scary because I've been in hospital for years but I just cant wait to get out and get on with my life..."

18.09.2019

"...I cant belive im being discharge cant wait The Dr is keeping my bed open just incase I need it but I don't think I will..."

152. I would like the Chair to be aware Norman Lamb MP was made aware in an email dated **26 June 2017** of the concerns that I had with regards to Abbi's care. His office stated that Norman had written to the Health Secretary at the time to raise these concerns. I believe it is essential that the Inquiry find out what action was taken by the Health Secretary at the time, in response. I remember him discussing Abbi's case and saying that he was worried that something may happen if someone did not investigate the case / she did not receive appropriate support. Noted below is information that was passed on to Norman's office:

"...Abbigail is 22yrs old she has had a terrible journey through Mental Health Centre's as you can read below. Where we are at now is, Abbi has just been transferred to another MH Centre last week in the name of Cygnet at Beckton, East London.

Now they have told Abbi that she will be placed there for probably 18mths, what concerns Lisa is what Goal are they aiming for and understandably after the damage that has been caused from the previous MH Centre's - aswell as Abbi having a learning disability and Autism - that she will need a Person Centred Package when she does leave this Centre.

So what I would very much like is, if Norman can find time to visit Abbi and ask general questions etc. I know he is awfully busy but this family surely need his support so things don't deteriorate anymore than they already have for Abbi.

Below: Abbigail's Journey

This is about my beautiful youngest daughter. She was diagnosed with learning difficulties at 3 and autism at 10. I have fought every day of her life to get support for school/ home/ transitions/ - you name the system and I have fought it, day in and day out.

When she was 15 - nearly 16, I asked the special needs school she attended for help because she was displaying some mild self harming behaviour and had been subject to an assault. I wanted her to be able to deal with her difficulties and the assault and not blame herself and I didn't want the mild self harming behaviour to become entrenched. I will never forgive myself for what followed;

Failings in the system

Children's services (inpatient)

Left sitting in a mental health unit on my own when the staff walked out of a meeting because they didn't like what I was saying. I was wandering round asking people to let me out.

Daughter not given a care plan for an inordinate amount of time and then it was not shared with me

Lies told to both my daughter and I constantly. This was a daily occurrence about anything and everything.

Diagnosis not being taken into account when treatment given

Daughter made to wait on unit for hours after headbanging so severely that her head was triangular and her forehead came out further than her nose, eventually taken to a&e

Incarcerated for well over six months and never been taken outside except into a small paved courtyard

I watched children being restrained with an adult's knee in their back

My daughter witnessed violence from staff towards children resulting in a broken arm and all being placed in humiliating situations

Trying to remove a set of rules from me because I wanted to take a photograph of the inhumane rules that the children were expected to adhere to, or else be punished by way of being placed in the Seclusion room (padded cell)

Placing my calls to my daughter on speaker phone with staff listening in

Preventing me from seeing my daughter when I started to question staff.

Myself and other daughter being told Abbi was asleep and couldn't talk to us, when we found out from other staff - she was awake and disappointed that we hadn't phoned.

Told me I didn't engage with services - I actually went to everything I was asked to, it was because I didn't agree with them that they told me I wasn't engaging.

Hid from me the fact that my daughter had a bank staff doing her obs and either slept or watched whilst she ligatured so badly, she blew all the blood vessels in her face.

Told Abbi she could go to her gran's funeral and then refused to let her go - Abbi has never got over this.

Told me abbi was too vulnerable to be transferred to the linden centre, yet when she was 18 this is exactly where she was transferred to.

Only let me have a 2nd opinion if they could choose that clinician. When I quoted that clinician he phoned me and told me that I couldn't go around quoting him.

Constantly moved the goalposts when abbi achieved what they asked and went back on the rewards they promised such as leave.

Adult services (inpatient)

9 moves in 18 months

Constantly allowing abbi to abscond resulting in many police searches - sometimes with helicopters and police dogs.

Allowing abbi to ligature necessitating in a&e admissions numerous times.

Not checking patients coming back into the ward from leave resulting in abbi overdosing on

paracetamol whilst in the unit.

Needing to relocate patients temporarily to disband a "patient mob" which staff couldn't control.

Allowing bullying from another patient towards my daughter resulting in my daughter crying down the phone to me and ligaturing that night.

Constantly allowing unsupervised leave when my daughter is diagnosed with learning difficulties and autism. Resulting in her not returning and trying to overdose whilst out - this happened several times. When they finally worked out she needed support to be out - she only had half an hour leave a day due to staff shortages.

Refused abbi leave to come back to my house overnight for her birthday and said it would be like granting her a holiday.

Allowing my daughter to be punched twice in the face, by a 67 year old man. I had pointed out his vulnerable and inappropriately placed abbi was.

Allowing abbi unescorted leave meaning she was able to spend time with a man I had previously raised a safeguarding alert about - resulting in her being given cocaine and alcohol.

Abbigail received absolutely awful care at St Aubyn Centre in Colchester. This is one instance of how poor the care was.

For those following my posts about my daughter, I want to try and recount a couple of incidents (I will try and do this one story at a time every so often), just to make noise and have people read and realise what happens:

Remember my daughter also has LD and autism as well as mh difficulties.

I went to visit her in the camhs unit and the psychologist came out. He told me that my daughter was refusing to see me. I had a meltdown and started saying that I demanded to see my 17(at the time) year old daughter and she could tell me if she didn't want to see me. He bought out a nurse instead and they both stood and argued with me. I told them they had no idea what it was like having a loved one in a place like this,,,,, that they could go home and the end of the day and leave their work behind, but for the families and their loved ones, it's a 24/7 nightmare that never ends. The nurse and psychologist actually shouted at me and told me that they did take their work home with them and that I didn't appreciate how difficult it was!!

I continued to argue that I wasn't moving until my daughter was brought out to me to tell me herself that she didn't want to see me.

Furious they took me through the security doors that connected reception with the wards and I waited in the corridor. Neither the nurse nor the psychologist reappeared but the door to the maximum security ward opened and my daughter was dragged out by two burly nurses. They literally had her under each armpit and were dragging her, she couldn't even move her own feet and her head hung down.

They dragged her into a community room and I followed them in, they sat her on a chair and I knelt on the floor and whispered her name. She looked up and had two black eyes, her forehead was swollen and so badly misshapen that her head was triangular and her forehead came out further than her nose.

I started to cry quietly, I couldn't help it. I told her I had bought with me "the wanted" annual that she had asked me for and she smiled at me and was able to say thank you.

The nurses were both still stood over her and said "are you finished yet abbi - you said you didn't want to come out here" followed by "it's nearly dinner time, you have to go back in". Abbi ignored them and I carried on gently chatting, ignoring the injuries, I was in shock and couldn't comprehend what I was seeing.

I told her she looked tired and to go back and that I would see her again as soon as I could. I left, walked back to my car and burst into tears. I stayed incoherent and unable to drive for a

good half hour.

I guess looking back I assumed these were medical people and knew what they were doing? Perhaps I did ask them about hospital I can't remember - I can just remember her being dragged out and the state of her face.

I started to drive home feeling helpless and 15 minutes later I had a call from a nurse who had come on duty, to say they had arrived in work and taken one look at abbi and insisted she be taken to hospital.

I turned the car around and met them at Colchester general. Abbi was there in a wheelchair with 3 members of staff. She seemed more alert and was able to interact more.

This was the first time in months and months that she had been allowed out of the front doors of the unit. She behaved appropriately, she talked and spoke, she interacted, she did as she was asked, she didn't try to abscond or hurt herself.

Hours later Colchester general discharged abbi back to the care of the unit staff, to be returned to the unit. We walked out of hospital together, we stopped in the car park and we hugged goodbye, she got into the taxi with staff and I got into my car, I watched her turn around and wave at me.

I drove home and allowed myself to cry all the way home - after not shedding a tear in front of her in the hospital. I got home eventually and received a phone call from the unit to advise me that abbi had walked through the unit doors and tried to strangle herself with her own hands. To me this is someone screaming that they cannot be in this place, that it is a living hell. I expressed this to senior staff the following day and I am told it is perfectly acceptable and quite normal and that actually my daughter felt safe enough in their environment and company to express herself.

I was dumbfounded that they still couldn't see what I saw.

Oh and I did pen this - along with other hideous incidents to the chief exec at the time - Andrew geldard.

He pushed the whole thing under the carpet and said if I had any further complaint to refer it to my daughters psychiatrist at the unit - one of the very people I had complained about..."

- a) I had started to document some of what was happening to Abbi on social media. Part of the above is a post that I had written.

October 2019 onwards- Discharge into the community

153. According to Dr [C]'s statement, Abbi was then:

"... discharged in October 2019 to the specialist psychosis team and monitored via an outpatient clinic, where she was prescribed Clozapine 150mg.

30. Miss Smith remained in the community until her admission on 25 January 2022 following head banging episodes and attempts to self-ligature..."

154. To explain in greater detail where Abbi then went, I have quoted from the section of Dr [A]'s report entitled "Summary of progress notes..." – next to the date 19.01.20, the report states:

*"Abbigail was discharged from Cygnet Hospital in Beckton London to **Pavilion Court** (intensive enablement accommodation) in Braintree on the **18/9/19**. She has a diagnosis of Simple Schizophrenia. She was on Clozapine 150mg twice a day at that time. she has had intervention in the past for developmental disorder, emotional disorder, social functioning disorder, BPAD, OCD, anxiety, DSH & suicidal ideation. Her care had been handed over to the psychosis team from SMHT on 16.10.19". (emphasis added)*

155. An extract from Abbi's diary with owls on the cover states:

31.05.2021

"...I was very upset and I don't know why so after I got back from horse riding I took this thing in the toilet with me and I strangled myself with it because I wanted to die...I just wanted to kill myself..."

156. With regards important events during this time period Dr **A**'s report gives the following information:

*"...5.13. Within a Care Review/Care Plan dated 13 October 2021, Dr **C** notes:*

5.13.1. 'I was contacted on 6th October 2021 about this lady who is seen in my trainee's clinic, to say that she had informed the team, that she had come off the CLOZAPINE. Apparently, it has been a few months and is now beginning to deteriorate in her mental health. She has a diagnosis of Simple Schizophrenia, Borderline Learning Disability and Emotionally Unstable Personality Disorder.

5.13.2. I asked her to come in and see me for 10 minutes today, 7th October 2021. During this emergency appointment, which Abbigail attended with the support worker from Pavillion Court ... informed me that she actually forgot to take the CLOZAPINE for a few days and then became non-compliant with it and it has now been 3 months since she has taken the medication. She has noticed that her mood has crashed and she is feeling quite low and suicidal ... said that she is hearing voices telling her to harm her partner and to harm herself'..."

157. With regards to events on **7 October 2021**, the PSII report states:

"...7th October EPUT

Abbigail attended her urgently scheduled medical review; her accommodation staff were in attendance. It was noted that she had experienced early symptoms of relapse and had agreed to recommence clozapine. The clozapine nurse was asked for this to be arranged. Abbigail was provided with seven days of Quetiapine 100mg and Promethazine 50mg to take at night, to utilise whilst her clozapine dose was being re-titrated. It was suggested that Abbigail would be offered support every other day by the community team. Abbigail's GP was informed of the appointment outcome in writing..."

158. With regards to events on **11 October 2021**, the PSII states:

"...11th October EPUT

Abbigail attended A&E and was referred to the Mental Health Liaison Team at 01:50hours, and was assessed by two clinicians at 02:48hours. She was in the company of her partner. Abbigail reported that she heard voices which told her to harm herself and others and felt unable to maintain her safety. She had not acted on the voices commands. She had thoughts to overdose, but her tablets were held by her supported accommodation staff. Abbigail felt safer to maintain her safety in A&E overnight and to consider admission in the morning. Abbigail and the clinician discussed how admission may isolate her from her regular support which helped maintain her safety and that A&E was not the only way in which admission could be arranged. It was agreed for her to engage with her usual care team, to support her initially and consider admission if this were not successful. She accepted Diazepam 5mg to manage her anxiety and returned home with her partner. The clinician requested for the Specialist Psychosis duty clinician to make contact with Abbigail. Abbigail's GP was informed of her attendance, in writing.

At approximately 10:00hours, Abbigail was contacted by Sanctuary and presented as withdrawn. Abbigail reported that she continued to experience nightmares and how she was going to stab herself in the neck, jump from a window and kill her partner. She was tearful when

speaking about this and was offered reassurance. Abbigail was reminded how to access services when she needed, in particular out of the working hours of Specialist Psychosis Team. Abbigail was discharged from Sanctuary.

In the afternoon, the Specialist Psychosis duty clinician visited Abbigail at home. She continued to experience hallucinations and did not feel her new medication was effective. She requested for admission to manage her medications and suicidal thoughts. She had protective factors in place, such as partner and her accommodation. She agreed to an appointment with the duty clinician the following day, as her care coordinator was on leave. In addition, the Consultant Psychiatrist increased Quetiapine to 200mg, Promethazine 25mg to three times a day and also provided seven days of Diazepam 5mg to use twice a day. Abbigail was aware of her crisis and contingency plan..."

159. With regards to events surrounding the cessation of Clozapine, Dr **A**'s report quotes from the witness statement of **[I/S]**, Interim Service Manager, dated 10 March 2023, as follows:

"...8.15.8. In October 2021, it is documented that Abbi had stopped taking her prescribed CLOZAPINE. Conversations were held with both Abbi and her Mum and it was agreed that Abbi was felt to be able to make decisions around her medication independently at this time. However, the situation rapidly changed and, on notification from Mum and from further concerns raised by Mum, a medical review appointment was made the following day with her consultant psychiatrist. During the appointment, it was noted Abbi was agreeable to restart in the interim QUETIAPINE 100mg nocte and PROMETHAZINE 50mg nocte was prescribed until titration of CLOZAPINE could be initiated. Abbi was monitored by the team daily however when visited by the CLOZAPINE nurse to discuss re-titration Abbi expressed that she did not wish to recommence..."

160. From my recollection of Abbi's Inquest, evidence was heard that Dr **C** was concerned that if Abbi did not go back on Clozapine, she would get '100 times worse', and the Mental Health Act would have to be considered.

161. From the section of Dr **A**'s report entitled "Summary of progress notes", it states:

"... 28.10.21 Abi showed staff the self-harm wounds on the backs of her hands and the heel of her palm. She appeared to be caring for these appropriately and there were no signs of infection. She reported that she done these a few days ago and has also written a suicide note to her mum and her sister. Abi reported feeling hopeless and helpless and that she is struggling to continue.

29.10.21 Abbigail reported fleeting suicidal thoughts and she stated that she is managing this by talking to Pavilion Court Staff or her friends. We discussed that it is positive that Abbigail is actively seeking support when she is low.

13.01.22 Abby spent some time telling me about the trauma that she experienced as an inpatient when she was younger. She said that she felt that the staff had been abusive and were not caring. We discussed how it is difficult as the staff would have been trying to keep Abby safe too which Abby recognises. Abby says that she has written all of the incidents down and let me read this. There did not appear to be anything particularly worrying from what I read. I asked Abby if she had told the police and whether she felt she needed to and she said that she would think about it. Abby was offered support to do this if she feels she wanted to. Abby said that she would think about it..."

162. With regards to the events on **24 January 2022**, the PSII Report states:

"...Abbigail was referred to the Broomfield Mental Health Liaison Team at 09:26hours. The referral noted she had superficially wounded her throat, neck and arms. She had also attempted

to ligature. Abbigail was under the influence of alcohol at the time. The records by EPUT state that Abbigail had informed accommodation staff who contacted emergency services who transported her to hospital, accompanied by the police. Whilst in A&E, Abbigail attempted to self-harm and tried to leave the department which was difficult to A&E staff and security to manage her risk. It was deemed necessary to have administered IM medication to prevent further harm to herself.

At 09:44hours, the MHLT clinician made attempts to engage Abbigail in assessment, however she declined. She expressed concern that she did not wish to be admitted to hospital because she would be there for "years" but did not engage enough for a safe discharge plan to have been optimised. Attempts were made for Abbigail's care coordinator to be contacted to support, however MHLT clinician was informed that they were off duty. The duty clinician in the Specialist Psychosis Team was unable to attend to support.

Abbigail presented with recent self-harming and repeated attempts whilst in A&E and expressed that she wanted to die, so a plan was formed for Abbigail to be referred for assessment under the Mental Health Act. The referral was made at 10:27hours by the Mental Health Liaison Team clinician. Within the referral, the reasons for her attendance in A&E was noted.

In addition, the referral documentation included details that Abbigail had presented with aggressive behaviour and she had been violent towards her family; where she had growled, spat, shouted and had swung from ceiling lights and defecated in the kitchen. Upon review of the clinical records as part of this investigation, this information was included within the general hospital's records subsequently scanned into EPUT's clinical records system, **however these details were related to another patient.**

Abbigail's mum was contacted to provide collateral information. Abbigail's mum informed that she had been well however had ended the relationship with her partner, and whilst this had been identified as positive, Abbigail had become more focussed on the relationship and why her ex-partner acted the way he did. In addition, a recent report had been released about an inpatient unit Abbigail had stayed in, which had bought her experience to the "forefront of her mind" and what she had been "subject to and witnessed awful things". Abbigail's mum also acknowledged that she had stayed with them over the Christmas period as they had to isolate together, and Abbigail since returned to her accommodation alone.

Abbigail's mum reported that when Abbigail felt low in mood, she consumed alcohol and binge-drunk which impacted on her judgement and decision making.

Abbigail mum felt that inpatient admission would have a detrimental effect on Abbigail and was more stable when in the community. Abbigail's mum expressed the level of risk that Abbigail could present with if she were admitted; and felt that she would "find a way to kill herself if admitted". Following review of the report, Abbigail's mum stated that she recalled informing staff that Abbigail required more support in the community in order to engage with life in a meaningful way and inpatient admissions were not the answer.

The content of the conversation with Abbigail's mum was handed over the AMHP and Psychiatrists prior to the Mental Health Act assessment.

The supported accommodation Team Lead made contact with the Specialist Psychosis Team duty clinician, where they expressed concern that Abbigail left in an ambulance the previous night and had not returned. The duty clinician liaised with MHLT to obtain an update and informed the Team Lead that she remained in Broomfield Hospital. The records shared by Abbigail's accommodation provider show the same information. In addition, accommodation staff informed Abbigail's mum of the update.

Abbigail was assessed under the **Mental Health Act** at 18:55hours. Abbigail informed that she had been for a drink with some friends, and they had returned to her accommodation. An argument broke out, which resulted in Abbigail nearly being pushed as she put herself in between her friends to prevent them from arguing further. Following this, her friends left and Abbigail broke a glass ashtray and informed accommodation staff to remove the glass and was taken to A&E.

Abbigail recognised that triggers to her deterioration may have been related to flashbacks of abuse [I/S] She reported suicidal thoughts, and consumed alcohol to reduce her thoughts. Abbigail reported that alcohol can cause for her to feel more emotional but had trusting relationships with staff and family for times when she felt low. Abbigail reported to have been concordant with her medication. Additional information in relation to Abbigail's previous history with mental health services was obtained from records systems. Both Section 12 approved Doctors concluded from the assessment that Abbigail did not meet the threshold for detention under the Mental Health Act and was offered involvement from the Home Treatment Team.

The referral to Home First was acknowledged on the same day and they agreed to review Abbigail's needs the following day..." (emphasis added)

163. With regards to the telephone call with myself, which is mentioned above, which I believe was from a clinician/ social worker, I have the following comments to make. The clinician /social worker informed me that Abbi had presented at hospital and asked me what I wanted to do with regards to this. I was incredibly confused, as up until this point most people had disregarded my caring role. I was incredulous, how could I decide on Abbi's behalf and why were they involving me now when clinicians had pushed me out of her life for eight years.
164. I replied truthfully that I was more worried about Abbi when she was an inpatient as these admissions seemed to have such a negative effect on her. The admissions led to very long-term periods of her being incarcerated. I informed the clinician/social worker that my belief was that Abbi needed more support in the community to engage with life in a meaningful way and to feel a valued member of society as she had simply been cast aside and left to rot. I explained that she suffered from terminal loneliness as services/ her housing wardens did not engage with her in a meaningful way and that to section her for this didn't give her the support she needed.
165. From this, the clinician / social worker agreed that she felt Abbi needed more support at home and that she would arrange for the community treatment team to go out and see her. The clinician said she would stop the 'gatekeepers' in order to provide the community treatment team support - Abbi was discharged. I didn't realise that "extra support" meant a five-minute pop in call to check on her. I thought, in my ignorance, that it meant a more sustained and intensive package of support for her. I wish I had been informed about, in my view, what were very 'light touch', pop-in visits that the Community Team provided. In my ignorance I thought it was intensive, at home support.
166. Dr A's report states:

"...5.16. Within a Care Review/Care Plan dated 27 January 2022, Dr N (Associate Specialist Psychiatrist) notes:

5.16.1. 'I reviewed Abbigale on 24th January 2022 at A&E, Broomfield General Hospital within the context of a Mental Health Act Assessment. She is 26 years old, is open to the Community Mental Health Team with a diagnosis of Simple Schizophrenia, Emotionally Unstable Personality Disorder, and Borderline Learning Disability ... has been residing in a supportive accommodation and her mental state has been relatively stable until recently. However, her mental state has been deteriorating since she broke up with her [I/S] ex-boyfriend of 18

months a few weeks ago. She is vulnerable to exploitation, especially when under the influence of alcohol ... stated she recently invited a boy to her accommodation, but felt terrified when he became threatening and violent towards her.

167. With regards to events from **24 – 26 January 2022**, the section of Dr **A**'s report entitled "Summary of progress notes" states:

"On 24.1.2022 Abi was detained on S136 by police and brought to A&E after tying ligatures to her neck. She was highly distressed and required police restraint. She was noted to be drunk on vodka. Abi was assessed under the MHA. During the assessment she was calmer and sober. She agreed to work with HTT and was not admitted to hospital. Over the following two days Abi continued to present with elevated risk of suicide and self-harm by ligature and head banging. She continued to drink alcohol (up to 1 litre vodka daily) and HTT were unable to maintain her safety in the community.

On 26.1.2022 Abi was brought to A&E by ambulance due to ligaturing and head banging. While at A&E Abi has required restraint, sedation under the MCA and two security guards to monitor her. At interview Abi expressed planning an intent of suicide. She repeatedly stated she was to go home to drink alcohol and to choke on her vomit. She could provide no assurances about maintaining her safety and was ambivalent about mental health support, saying there is no point. She consistently declined informal admission.

Abi is presenting with a highly elevated risk of suicide by ligature, with planning and intent and highly elevated risk of severe injury through head banging. She intends to continue drinking alcohol which is identified as a key risk indicator – due to the impact on her mental state and the disinhibition it enables.

Abi has also been presenting as increasingly vulnerable to physical and sexual exploitation when inebriated..."

"...25.01.22 Abbi and I spoke about recent triggers to crisis and we identified the end to her most recent relationship one month ago may likely have brought up some feelings surrounding fear of abandonment and she said that this relationship was very toxic so her self-confidence is at a low. She said the relationship last a year and a half and the last time she remembered being happy was two years ago when she moved into her flat and decorated – we talked about emotions being temporary and the reality of suicide being very permanent and she reported that she still feels very hopeless and wanted to go get drunk and smash a bottle and use it to harm herself. When I asked her what was behind these feelings she began to cry and we talked about how she struggles to express her feelings and we also talked about this in relation to her diagnosis EUPD.

She said she lacks some understanding into her diagnosis and she agreed she finds it all less overwhelming when her trigger points are broken down via talking through this together. She said she has something in the home to ligature with but refused to hand this over to me – she said she feels she would need an admission in order to feel safe and I advised that she can discuss this with the Home First Team..."

168. With regards to **26 January 2022**, Dr **A**'s report continues to state:

"5.17. Within a Mental Health Act 1983 Assessment dated 26 January 2022, it is noted:

5.17.1. 'On 25th Home Treatment Team attended the home address and client voiced that she still has feelings of wanting to end her life and had a ligature in the home that she refused to surrender.

5.17.2. Client has also been drinking alcohol for a few days.

5.17.3. The team went today and client was still head banging and attempting ligature. An ambulance was called and client was agitated and had to be restrained and also attempted to strangle herself with her hands’.”

“5.17.9. I informed Abi that we were told she had attempted to tie a ligature yesterday. Abi acknowledged this and said she used a bra. I asked what she wanted to happen when she did this. Abi shrugged her shoulders and said “people don’t want me here”.

5.17.10. Abi repeated that she wants to go home and asked if she could order a taxi. I asked what she would do at home. Abi said she would drink, cry, “hope to choke on vomit”.

5.17.11. Dr [N] asked Abi if she would agree to hospital admission for a couple of weeks to stop this cycle of repeated self-injury and alcohol use. Abi said no thanks. I asked Abi if she wants things to change. Abi said “I don’t see the point”. I asked if she thinks her situation can improve. Abi said no and began to become tearful.

5.17.12. I advised Abi we were aware of the MHA assessment 3 days ago and the plan for her to work with HTT. Abi said they have been visiting. I noted that despite HTT input Abi has continued to harm herself and attempted suicide several times ... asked Abi what help she thinks she needs. Abi said she doesn’t know, then stated she wants to go home.

5.17.13. Without prompting Abi told us she made a suicide video. She said this was before the last MHA assessment ... has kept the video and told us it is her thanking her friends and saying goodbye’.”

“5.18. With regard to the professional discussion, the same document notes:

5.18.1. ‘Dr [N] noted that Abi can make no assurances for her safety. Her risk to self cannot be safely managed in the community and she requires crisis admission for her own safety. Dr [N] noted that Abi’s diagnosis of ASD has not been clarified and he questions the diagnosis of simple schizophrenia. He thinks the EUPD diagnosis reflects her presentation and needs.”

“... 5.19. With regard to the views of [O], it is noted:

5.19.1. [O] thinks that the supported accommodation provider would not be able to manage the presenting risk to herself even with on-going HTT input.

5.19.2. [O] noted that a lengthy hospital admission is unlikely to be helpful, but thinks that there are no other options but admission to contain the risks to Abi at present.

5.20. With regard to the Views of Acting Approved Mental Health Professional, it is noted: ‘Abi has not had a hospital admission in recent years, the precipitants for this period of crisis are not fully understood and she would benefit from further assessment of need (e.g. Care Act assessment and OT ADL assessment). Considering the nature of Abi’s mental disorder – with known escalation in self-injury when in hospital – it is recommended that admission is kept to the minimum length possible while maintaining her safety. With this in mind both doctors and I agreed to detention under S2 MHA’.”

169. With regards to the above entry at paragraph 5.17.11 of Dr [A]’s report, everyone is so caught up about Abbi’s use of alcohol, but people don’t realise that again Abbi showed people what she wanted them to see, such as in her video where she talks about “needing” a drink of vodka. In December 2021/ early January 2022, Abbi was at home with Greg and me for over 10 days because of covid. Not once during these 10 days did Abbi ask for alcohol. She didn’t leave the house and so didn’t buy any. Yes, we had a glass of wine with Christmas dinner and may have had a glass of wine in the evenings occasionally. I feel it is really important that people recognise Abbi’s true persona. She did binge drink once she started, and as a family we kept an eye on it when she was out with us, but she struggled to realise or understand limits when she was alone or with friends.

170. My understanding of the events during this time period are as follows.
171. Abbi came to stay with Greg and me for Christmas 2021 in Romford, she stayed with us every year. We all caught Covid, so we were all isolated together for 10 days, meaning Abbi had company, meals and entertainment for those days, something she did not have in her own flat.
172. When she went back home in early January she started to struggle almost immediately, although I didn't realise this at the time. A few weeks after she went home – I believe it was the **24 January** – I was told she walked into the wardens flat at her complex and had part of a glass ashtray sticking out of her arm. I cannot remember whether it was Abbi or the wardens who informed me of this. The warden called an ambulance; the paramedic turned up and promptly called the police. I have no idea why the police were called! They took Abbi to the nearest hospital where one of the members of staff phoned me and asked me what I wanted to happen – I have discussed this conversation above. Abbi was discharged back into the community.
173. The next day, the **25 January**, from memory my understanding of the events is as follows – The community team popped in to check on Abbi. At one point Abbi went back to the wardens after they had left and said that the warden needed to call an ambulance and that she was going to hurt herself. I understand from the PSII that she also shared with staff at Pavilion Court that she had made a suicide video. The wardens called an ambulance and when the ambulance turned up Abbi started headbanging in front of the paramedic, who called the police again! She was taken back to Broomfield Hospital A&E but she was again discharged with a quick pop in call from the community team scheduled. With regards to events on 25th January, the PSII states that “...*They reflected that the arrival of the ambulance may have escalated the situation...*”. There are witness statements prepared by (e.g. the paramedics) which go into greater detail of the events which took place. From memory, no one from Broomfield bothered to ring me to inform me that my daughter had been conveyed to A&E again.
174. The events of the following day, the **26 January**, were very chaotic and, to me, sounded like a three-ring circus.
175. I understand that Abbi was seen by the community team, during which time she was tearful and drinking, which she shared with the team was to deal with her emotions. However she did not want to discuss this further so staff were to return the next day. My understanding is that the community team have a policy where they don't substantially engage with anybody who is drunk.
176. With regards to **26 January 2022**, the PSII report states:

“...Following this visit, supported accommodation staff informed the Specialist Psychosis Team duty clinician that Abbigail had been observed to stumble in the car park, had shouted and fell over. They called for an ambulance. The duty clinician attended the accommodation, where they observed Abbigail to be intoxicated. Friends had attempted to prevent Abbigail from falling, however she fell backwards and hit her hard on the concrete floor. Abbigail was unconscious for approximately ten seconds; first aid was attempted however Abbigail was agitated and rolled around the floor. Abbigail agreed to lay on her side whilst her injuries were assessed and a large red mark and bump were evident. Clinicians attempted to monitor her pulse however she was agitated and therefore a reading could not be taken. Her breathing was stable.

Supported accommodation staff were asked to inform the ambulance that further injury had occurred of an unknown severity. The ambulance arrived and the crew attempted to strap Abbigail to the trolley. Abbigail released herself from the restraints and fell forward which caused an injury and bleeding to her forehead. Abbigail was also observed to hold her hands round her

neck and they were removed. Police were also called and Abbigail was conveyed to hospital via blue light ambulance...”

177. In summary, I think the whole process over those few days was a debacle. I have heard stories about there being police body worn camera footage, Abbi getting her necklace ripped from her body and being restrained as if she were a criminal. I would like the Inquiry to obtain and review any police body-worn camera footage. At a time when it appeared she needed love, care, and understanding, none of these appear, upon the face of it, to have been shown to her. Abbi was treated worse than an animal or a prisoner. In general, she appears to have been shown no empathy / no understanding and her autism certainly doesn't seem to have been taken into account. I do recall hearing during Abbi's Inquest that [I/S] the paramedic who attended on one of the days, showed Abbi empathy and tried to prevent her from headbanging by placing his hand between her head and the wall, during which he sustained an injury. I would like to convey my deepest thanks to him for showing my daughter this kindness. It is [I/S] who maintains that once in hospital, he heard one of the clinicians say that Abbi should just be left alone and that she would eventually 'knock herself out'.

178. I understand that at some point Abbi was the subject of a safeguarding management plan. I was informed that a staff member called [I/S] reported she observed Abbi in a holding room with security personnel, that Abbi was trying to head bang and the security officer was restraining her inappropriately by holding her from behind with his/her hands on Abbi's chest. I would like the Inquiry to investigate this incident further. I have since been made aware that this was the day that Abbi had tried to ligature with her bra, which had been removed. This makes the restraint all the more concerning, and probably all the more traumatic for Abbi. I have also discovered a picture on Abbi's phone from 26th January which appears to show one person, possibly a security guard, asleep in a chair next to her – presumably whilst being there to ensure her safety and conduct observations of her.

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179. I had a phone call to tell me that they were so concerned about Abbi that they needed four crews to be able to transfer her safely to Basildon Hospital Mental Health Unit (as Galleywood Ward was closed because of Covid). I understand that when she was transferred she was on level four, 2:1 observations. I would like the Inquiry to look into whether it was the case that these crews were not immediately available, and if this led to Abbi's protracted stay in Broomfield A&E. The reason being that it cannot be beneficial for someone in Abbi's mental state to be in an A&E department.

180. With regards to events on **27 January 2022**, Dr **A**'s report states:

“...7.3 Within an NHS Mid and South Essex NHS Foundation Trust 'MSE – Incident Management and Investigation Form' regarding an incident at 0330 on 27 January 2022, it is noted: 'At approximately 03:30, the emergency alarm bell went off from Mental Health rooms, I was nurse in charge of short stay area on AMU and went to help. I found a security guard in the room and patient A.S was on the floor and had tied 2 ligature to her neck. She appeared cyanosed I called for help and Short stay nurses came and I cut the ligatures with a scissors. I applied 15 litres of oxygen from the crash trolley and called the medical team to assess patient. Patient became more perfused. I could not see any members of the mental health team. Once patient was safe I went to look for them and found them in another room assessing a patient. I carefully knocked and asked if could talk to them re their patient and what had happened to her. Mental health Nurse S said that he was mid assessment and that it was inappropriate to disturb him. I tried to stress the seriousness of the situation with his patient as I felt he needed to come and see her and told him that the emergency bell was for one of the mental health rooms. He begrudgingly came out and I informed him of the situation but he did not come to the patient ... asked me where the security guard

was. I stressed the importance of him coming into the room to see what was happening but he didn't follow ... then went to find the site team GA to ask for help and advice but met SR site instead'..." (emphasis added)

181. The following timeline of events is from various aspects of Dr **A**'s report.

182. Appendix 1 of Dr **A**'s report states:

"...27th January ECC ... she was detained under Section 2 of the Mental Health Act... She was visibly distressed and attempted to leave the room. Whilst she remained in the mental health suite, she attempted to ligature with socks on two occasions and required restraint by hospital security....

...27th January EPUT ... Abbigail's mum provided additional information about Abbigail's needs. She reported that she had significant processing issues, whereby she would be present for a conversation but may not absorb the content and outcome. She informed that previously in ward rounds this had caused issues, because Abbigail could misunderstand the information. She also spoke about Abbigail's attempt to mask her autism and provided an example whereby Abbigail would "parrot" phrases that she had heard without understanding of the meaning. Abbigail's mum also advised that Abbigail had limited sense of time and struggled to read a clock...

...27th January EPUT AT 17:00hours, the transport arrived however it was deemed that Abbigail required additional staffing to escort her as she had been unsettled and at risk to herself.

At 21:10hours, Abbigail was transferred to Basildon Mental Health Assessment Unit, the AMHP was in attendance...

It was agreed that Abbigail would be nursed on level four observations due to her risk. After she had entered her bedroom, she attempted to bang her head and staff were required to intervene and reassure her. She attempted to bang her head again and was visibly distressed. She reported that she wanted to consume alcohol to cope with the voices in her head. Two staff members remained with Abbigail and held her hands. It was agreed that she would be nursed on level four observations 2:1 to ensure her safety...

The Duty Doctor was contacted to prescribe PRN medication. Promethazine 50mg and Lorazepam 2mg was prescribed, although Abbigail declined both. She continued to struggle and make attempts to harm herself so the medications were administered via IM..."

183. Appendix 1 of Dr **A**'s report continues to state:

"...28th January EPUT During the day, Abbigail was observed to attempt to bang her head ... expressed that she did not want "to be here"...

Abbigail informed that she had consumed a bottle of vodka a day to cope with her feelings ... Later in the day, she was observed to make attempts to ligature.

...Abbigail had bruising to her left eye line with minor swelling and she was unable to open her eyelid..."

...29th January EPUT Abbigail was reviewed in the ward round... Abbigail attended and reported that she had managed well since her last admission in 2019; however in recent months had split with her ex-partner. [I/S]

The ward nurse informed that Abbigail has several videos of her self-harm...

...30th January EPUT Abbigail was observed to have a video call with her ex-partner. She was overheard saying "this would be the last time you see me" and her ex-partner was observed to cry. Her ex-partner made contact with the crisis team to inform that Abbigail was alone and may be at risk and this information was handed over to the ward staff. Abbigail remained on level four observations with two staff members. Abbigail was encouraged to contact her ex partner and inform him that she was with two staff members...

...31st January EPUT ... IM medication was administered which helped Abbigail to return to a calmer mood...

...1st February ECC A safeguarding concern had been raised from when Abbigail was in general hospital and security staff utilised an inappropriate restraint hold technique. A safeguarding management plan was activated, and alternative security was allocated.

1st February EPUT ... Abbigail contacted her care coordinator from the ward. She informed that she had banged her head since being on the ward and this required medical attention. Abbigail asked her care coordinator for support "to get out" and was advised that this would be an MDT decision and they would make efforts to attend the ward round. Abbigail was advised that her self-harming may prevent discharge, and Abbigail informed that she would end her life if she were to be discharged from hospital.

...She requested to be discharged and informed that she felt better with no suicidal thoughts. She reported a trigger to her suicidal thoughts prior to admission were the thoughts in her head.

Initially she was reluctant to speak about this further, but with encouragement she reported that she has experienced traumatic events and experiences suicidal thoughts when "things do not go well". She discussed the breakup with her ex-partner and was unsure if this was associated with her suicide attempt.

Abbigail asked for discharge and felt that she would be safe and she would not make attempts to harm herself... it was agreed for her level of observations to be reduced to one staff member.

...In the evening, Abbigail attempted to ligature with socks which resulted in physical intervention to reduce the risk of harm and remove the item. IM medication was administered. Her level observations were increased back to two staff...

...Abbigail rose from bed and banged her head against the wall..."

184. Under the title 'Summary of progress notes' Dr **A**'s report continues to state:

"...01.02.22 Abby said asked me if I could 'just get her out of here' and 'tell the ward staff to let her go'. I informed Abby that I could not do this as it was an MDT decision however I explained that I had been trying to attend the ward review. Also explained that Abby knows that her current self-harming behaviours are not going to mean that she is discharged from hospital. Abby informed me that she would end her life if she was discharged from the ward..."

185. Appendix 1 of Dr **A**'s report continues to state:

"...2nd February EPUT ... she was observed to bang her head against the wall in the garden. She required physical intervention from staff to stop, and IM medication was administered..."

...3rd February EPUT Abbigail presented as agitated and required physical intervention, as she had banged her head against the wall in her bedroom. IM medication was administered...

...She was pending transfer from the Assessment Unit to Galleywood Ward in the evening and left Basildon Hospital at 20:00hours...

On arrival to Galleywood Ward, the ambulance crew who transferred Abbigail informed the nursing team that she was a risk of absconscion and had attempted to bang her head on the floor during transfer...during assessment reported that she felt hopeless, helpless, worthless with suicidal thoughts. She stated that she did not wish to be in hospital and would prefer to return home.

She expressed a risk to herself if she were to be discharged. A decision was made for Abbigail to be nursed on level three observations..."

186. Dr [A]'s report states:

"... 5.25. Within an Initial Assessment of Needs and Risk, dated 3 February 2022, it is documented that Lisa Wolff 'reported [Abbigail Smith] that she attended a special educational needs school as mainstream schooling could not meet her educational needs. Mum reported that Abbigail has no meaningful occupation or structure to her day'.

5.26. The Initial Assessment provides no information with regard to Abbigail Smith's use of alcohol or illicit drugs and notes risks related to 'suicide', 'deliberate self-harm', 'absconding behaviour', 'likelihood of disengagement/non-adherence with treatment plan', 'risk to health/medical condition' and 'risk to self/others through use of alcohol'.

5.27. The Initial Assessment does not provide any information related to 'Full details using a patient's own words where possible' aside from: 'Alcohol makes her emotions more intense and this makes suicidal and self-harming thoughts likely to occur. Currently she is harbouring active suicidal thoughts and thinking about drinking self to death by choking'.

5.28. Further, the Initial Assessment does not provide any stratification as to whether any of the highlighted risks are 'high risk', 'medium risk' or 'low risk'.

5.29. The Initial Assessment provides no 'Information from relatives or carers' and further provides no 'Initial formulation/summary of needs and risk discussed with patient or carer'.

5.30. It is noted that there is no information within the 'Patient views and initial goals "What would you like to achieve"' section.

5.31. Within an Inpatient Admission Assessment dated 3 February 2022, it is noted:

... There is a documented risk of vulnerability due to alleged sexual, physical and emotional harm from [I/S]

[I/S]

... More recently she appears to have used alcohol in a dependent manner.

... Personal History...ND. Delayed speech + ACE + Developmental trauma...

... she herself was allegedly physically abused

... Was diagnosed with ASD at the age of 10 years.

... Reported being bullied at school

... She is unclear about the possibility of sexual abuse when she was 16...

...5.33. Within the Care Plan in relation to Abbigail Smith dated 3 February 2022, it is noted '... Currently she is harbouring active suicidal thoughts and thinking about drinking self to death by choking...'

187. Appendix 1 of Dr [A]'s report continues to state:

“...4th February EPUT ... Abbigail tied a ligature. An incident report form was completed which contained more information. It suggested that Abbigail had forced herself into the toilet and locked the door because the observing Nurse was able to respond. A female staff member attended and they unlocked the toilet door where Abbigail was observed to have tied a ligature using her socks...

...Abbigail was observed to lift a hood over her head. Staff intervened and recognised that Abbigail had tied a shoelace around her neck...

Abbigail was reviewed in the ward round. Galleywood Ward Consultant Psychiatrist and Abbigail's care coordinator discussed Abbigail in detail. Abbigail's care coordinator informed that she has lengthy admissions in the past and agreed that this admission should be short in length. They felt that with evidence of future planning by Abbigail, and a robust support package post-discharge, they would support discharge planning. They explained that Home First involvement had not been beneficial prior to admission. It was noted that Abbigail was at risk of accidental death due to her misadventure with risky items. Abbigail's care coordinator agreed to attend ward round the following week.

In addition, collateral information was obtained from staff at her supported accommodation. They informed that Abbigail's mental health had declined following discontinued Clozapine and further after she broke up with her partner. It was also noted that Abbigail spent time with her mum over the festive period and they isolated together due to Covid-19 and when Abbigail returned to her accommodation she needed to readjust to not being with others all of the time. It was felt that she had declined in the three weeks prior to admission. [I/S]

[I/S]
[I/S] The staff member informed that they were on shift for two of the incidents whereby Abbigail had been under the influence of alcohol. When she was medicated, she had fewer incidents of this nature. They stated that the other individuals lived within the accommodation and they did not have a dedicated resource to support Abbigail 1:1. The staff member queried whether Abbigail felt concerned that she would need to move on from her accommodation.

During her review, Abbigail reported to have consumed vodka daily, and the police were contacted. She informed that she had been located with a cord around her neck by the police. When asked of the triggers, she spoke about her challenging relationship with her ex-partner [I/S]. At the time she was unsure if a safeguarding concern had been raised by her care coordinator...

Abbigail reported that she wished to return home to consume alcohol... She asked to be placed on level two observations and “to leave me to it” and was advised that she would be nursed on level three observations with a plan to review after the weekend.

Abbigail was asked if she needed support with her alcohol use, to which she declined. She reported that she used alcohol to cope with her emotions...

In the evening, Abbigail banged her head and attempted to ligature with her blanket...accepted PRN medication.

4th February Pavilion Court *The records shared by Abbigail's accommodation provider show they were contacted by Galleywood Ward staff to inform them of Abbigail's location and to request more information about Abbigail's presentation. In addition, the accommodation provider informed the investigators that their service is a “move on scheme” where residents develop independent living skills for a period of up to 24 months, after which they are supported to move on. Abbigail's tenancy commenced in September 2019 and therefore her “move on” planning should have commenced; however as she underwent changes to her medication and*

she presented with fluctuating mood with a hospital admission, it was not felt appropriate to plan for her move.”

188. Under the title ‘Summary of progress notes’ Dr **A**’s report continues to state:

“...04.02.22 Dr **Q** explained that although Abby is expressing suicidal thoughts in hospital and upon discharge into the community, he says that there is evidence of future planning. I explained that I am concerned about the risk of accidental death in hospital as well as this increasing in the community ... cannot comment on intent or future planning as Abby has not mentioned this to me when I have been in contact with her...”

“...05.02.22 Mother told me that Abbigail has been a “square peg in a round hole” for a long time. She recounted about how A.S came to be diagnosed with ASD ... said that in-patient admissions have not helped A.S in the past and in fact it had worsened her presentation ... reflected on the significant amount of time A.S has spent in in-patient units, she is of the view that A.S was traumatised by 2 in-patient suicides that she witnessed while in St Aubyn’s centre and is of the view that she has PTSD symptoms as a result of this experience. She added to say that A.S can be attention seeking as well. Mother is of the view that A.S will benefit from more support for her in the community through her local CMHT, to have activities to structure her day and to have psychological/psychotherapeutic interventions in the community.

Mother works as a social prescriber across several GP surgeries in East London ... said that A.S does not understand the concept of time ... will forward information on A.S’ s IQ testing and information pertaining her diagnosis of LD ... thanked me for listening to her today...”

189. Appendix 1 of Dr **A**’s report continues to state:

“...5th **February EPUT** ... Ward staff contacted Abbigail’s mum for collateral information. Abbigail’s mum informed that Abbigail was on the autism spectrum and had been in hospital before for significant periods of time and this had not helped her presentation. She communicated that Abbigail had been traumatised from her previous admissions, in particular due to two suicides she witnessed whilst on a ward. Abbigail’s mum felt that she would benefit from community support and activities to structure her day, alongside psychological interventions. Abbigail’s mum agreed to forward information on her IQ testing and her learning difficulties...”

6th February EPUT ... Her level of observations were reduced from level three to level two...

7th February EPUT ... The outcome of the meeting was for Abbigail’s care coordinator to be involved in discharge planning.

In addition, Abbigail’s observation levels were reduced from three to two...

8th February EPUT ... Abbigail has used a plastic laundry bag round her neck... Abbigail was observed to bang her head in the toilet... Abbigail was located in the shower having tied a ligature with her clothing...accepted PRN Promethazine 50mg...

Abbigail reported that she has a plan for when she was discharged from hospital and had asked nursing staff not to inform the Consultant in the hope that she would be discharged the following day. She was informed the Consultant would be aware of the conversation.

Abbigail requested for staff not to monitor her and allow her to die, to which she was informed that this would not occur...”

190. Under the title ‘Summary of progress notes’ Dr **A**’s report continues to state:

"...08.02.22 Datix ID: 222932 At 09.50 patient was observed in her room and appeared to be tying something around her neck, staff found that patient had got hold of a plastic laundry bag and was using this to ligature..."

Datix ID: 222934 At 15.15 during checks patient was in the shower room found to have tied a ligature from her clothing.

Patient states that she has a plan ready for when she is discharged and was trying to persuade staff not to inform the consultant of this so that she will still be discharged tomorrow, staff explained that this is not possible and that the consultant will be informed of this conversation.

Patient then went on to persuade staff to not do their checks to allow her to die, staff stated that this was an unreasonable request..."

191. Dr [A]’s report also states:

"...5.37. Within a Ward Review dated 9 February 2022, it is noted:

5.37.1. ‘Multi Professional Feedback: Abigail thinks she is going to be discharged today. She wants to go home. There have been some ligaturing attempts leading up to discharge.

... 5.37.5. Dr [Q] explained we would like to discharge on Monday with HFT input, so not today.

... 5.37.9. ‘Dr [Q] asked about alcohol and drug services – Abigail declined referral to this service as she doesn’t think there is any point to it.

5.37.11... She has currently denied having any active suicidal plans or intentions

... Risk of suicidality and self-harm cannot be ameliorated by a long in- patient stay, on the contrary, it fosters risk of dependence on the ward and could cause iatrogenic harm due to potential for institutionalisation.

... There is a documented risk of vulnerability due to alleged sexual, physical and emotional harm [I/S]

... There is risk of physical health deterioration – particularly during periods severe impulsive head banging episodes.

... 5.39. Within the Essex Partnership University NHS Foundation Trust Discharge Summary in relation to Abigail Smith prepared by Dr [I/S] (GP Trainee) and covering the admission from 3 February 2022 – 14 February 2022, she is afforded a discharge diagnosis of ‘Emotionally Unstable Personality Disorder’, with it further noted...

Risk of suicidality and self-harm cannot be ameliorated by a long inpatient stay, on the contrary, it fosters risk of dependence on the ward and could cause iatrogenic harm due to potential for institutionalisation..."

192. Dr [A] further states:

"... 5.41. There are no instructions with regard to a reduction in the prescribed benzodiazepines with Abigail Smith having been prescribed CLONAZEPAM throughout the duration of her admission.

5.42. Within e-mail correspondence from [I/S] to [O] dated 14 February 2022 at 12:25, it is noted: ‘We have seen Abigail Smith today in review and her discharge is planned for today. She said that her friend will be picking her up so said she will be leaving the ward around 3pm. We will confirm this with you once she has left the ward. I did speak with Home

Treatment over the weekend and they have advised that Care Co [Coordinator] will need to complete the 48 hour follow up and if there are any concerns you can make a referral to them'

5.43. Within e-mail correspondence from [I/S] to [O] dated 14 February 2022 at 14:12, it is noted: 'Apologies a link wasn't sent to yourself, did you attend the meeting last week? She has been reporting she is ready to go home , we are aware that her risks are longstanding and potentially chronic in relation to suicidal ideations ... did not express any active plan to end her life or any self harm urges ... has said she is happy with the plan and is aware you will be completing the follow up ... has been fairly stable on the ward, but has appeared anxious at times regarding discharge which is always the case ... has been bright on the ward when engaging with peers and staff so her mood has been good'.

5.44. Within Clinical Coding in relation to Abbigail Smith – and with regard to 'Hospital Spell Start Date: 27 Jan 2022 ... Hospital Spell Finish Date: 3 Feb 2022 (last modified on Friday 18 February 2022) – she is allocated diagnoses of

- ✓ F60.3: Emotionally Unstable Personality Disorder
- ✓ F70.9: Mild Mental Retardation without Mention of Impairment Behaviour
- ✓ F84.0: Childhood Autism
- ✓ Z81.8: Family History of Other Mental and Behavioural Disorders
- ✓ Z91.5: Personal History of Self-Harm..."

193. Under the title 'Summary of progress notes' Dr [A]'s report continues to state:

"...**09.02.22** It is noted that Abby had said to staff the day prior that she was going to end her life upon discharge and asked the staff not to tell Dr [Q] Dr [Q] was aware and we discussed this in the review. Dr [Q] is planning to discharge Abby on Monday 14th February. Abby requested that she is discharged today however it was explained that this could not be done as we needed to ensure that HTT were in place prior to discharge and that this could take some time. Abby seemed upset about this..."

194. Appendix 1 of Dr [A]'s report continues to state:

"...**9th February EPUT** ... Abbigail was hopeful that she would be discharged and it was noted that her mum was in agreement with a short admission with increased support in the community. Abbigail was informed that her discharge would be after the weekend, to allow time for a referral to be made to the Home First Team. Abbigail was in agreement with this plan. It was documented that Abbigail's care coordinator would make the referral to the Home First Team.

It was noted that Abbigail had expressed plans to end her life on discharge and did not want the Consultant to be informed of this. The Consultant was informed of this.

A plan was made for Abbigail to be discharged from Galleywood Ward on 14th February...

... Abbigail was observed to barricade herself into the television lounge with two other patients, using furniture. She informed that they had done this to protest and demonstrate that they wanted to be granted leave to smoke... Abbigail and another female were observed to take rubber beading from the fire exit door but were unsuccessful. They were not observed to harm themselves or each other so a decision was made to observe them from a distance and monitor. It was noted that they were more determined to continue their demonstration when staff engaged with them. One of the females exited after 30 minutes, whereas Abbigail and another female remained in the room for a further two hours.

Abbigail and the other female were informed that their behaviour may result in discharge from the ward. After they discontinued their protest, Abbigail apologised and reported to have been influenced by another patient...

In the evening, Abbigail had a verbal altercation with another patient...

10th February EPUT ... On level two checks, staff located Abbigail in her bedroom. She had removed the curtains, ripped them and had tied a ligature...

She was observed to cry whilst sat on the floor and stated that she tied the ligature because she was tired and did not wish to remain in hospital. She denied intent to end her life when she ligatured...

...Abbigail requested for a hoodie and was advised that this would not be granted because of her risk of ligature...

11th February EPUT ... At 12:00hours Abbigail attempted to contact her care coordinator and a message was sent to her care coordinator to return the call...

In the afternoon, Abbigail was observed crying in her bedroom...

In the evening, Abbigail requested for access to a hoodie and was informed that this would need to be reviewed with the MDT given her risk. She was observed to wear another patient's hoodie and was encouraged against this.

During level two observation checks, Abbigail was observed to have a plastic knife and attempted to harm herself with it...

14th February EPUT Abbigail was reviewed in ward round. Present was the Consultant Psychiatrist, three Doctors, Staff Nurse and Student Nurse.

During an information gathering session, Abbigail's care coordinator informed the investigators that they had not received a link to the virtual appointment and were unable to attend for this reason.

When asked if she felt ready for discharge, Abbigail reported that she did. She was offered a referral to drug and alcohol services, but declined.

In addition, she was informed that her care coordinator would follow up in the community and refer to the Home First Team if there was a requirement for additional input. It was noted that she presented with some anxiety related to her discharge. Abbigail was discharged from her Section 2 at 13:30hours and it was noted her detention was no longer required due to an improvement in her mental state.

Abbigail's care coordinator was informed via email that following her ward round Abbigail would be discharged from the ward. Abbigail planned for a friend to collect her at 15:00hours. The ward staff had liaised with Home First for them to provide input post-discharge, and were informed that Abbigail's care coordinator would be required to undertake a 48 follow up and refer into their team if required. Abbigail's care coordinator informed her supported accommodation staff.

Abbigail's care coordinator planned to make contact with Abbigail the following day to complete the 48 hour follow up. The ward staff noted that Abbigail's risks were chronic in nature and longstanding and she did not express thoughts or plans to end her life... The discharge note confirmed she was provided with five days of the following medications:

Clonazepam 1mg, twice a day

Quetiapine 300mg, once a day

PRN Zopiclone 7.5mg

This was dated 11th February as this had been written in preparation for her discharge..."

195. The section of Dr [A]'s report above with regards to 10 February, it states that Abbi had used the curtains to tie a ligature. Why is it that these were not anti-ligature curtains?

196. Under the title 'Summary of progress notes' Dr [A]'s report continues to state:

"...14.02.22...Abbigail was discharged from the ward at 13:45 as per plan.

15.02.22 Abby expressed suicidal ideation which appears to be ongoing on a long term basis for Abby ... did not express any firm plans to end her life but indicated that she could not ensure her safety. We briefly discussed hospital admission and Abby said that she feels a bit abandoned by the hospital for being discharged so soon. I discussed with her that the MDT had felt that this was counter-productive for Abby being in such an environment hence the escalation in behaviour and the antisocial behaviour of barricading herself in a room with another patient. We discussed how long term hospital admission had not been very beneficial for Abby in the past and hence why we are offering stepped up care in the community.

Abby discussed her thoughts and said that she 'doesn't want to go on anymore' and feels 'fed up of feeling down and being with her thoughts' ... says that she feels she has 'lived her life now' ... appeared hopeless however on occasions showed some future orientation in regards to wanting to have a scan on her brain following her headbanging in hospital and we spent some time discussing her future plans of wanting to live independently with a dog ... did not express any firm plans to end her life however could not give firm reassurances for her safety.

We discussed alcohol intake and how this has a depressant effect on her mood which Abby is aware of. Abby says she drinks 'to block out how she is feeling' ... alcohol intake has increased significantly since the split of her ex-partner [redacted] [VS]

Abby appears to have capacity in regards to her alcohol use and declined a referral to Open Road for her alcohol use at this time ... is aware that this increases her impulsivity, negatively impacts her mood however does not want to consider reducing her alcohol intake despite advise. We discussed whether Abby would like support in the form of talking therapy and Abby said that she doesn't think it would be helpful and does not want to be referred for psychology at present...."

197. Appendix 1 of Dr [A]'s report continues to state:

"...15th February EPUT Abbigail was visited by her care coordinator and a student nurse at 11:30hours... Abbigail presented euthymic in mood although was tearful on occasions...

Abbigail reported that she felt abandoned by the hospital when she had been discharged after a short period of time. She was informed that the ward staff had felt the ward was a restrictive environment and this may have escalated some of her behaviour and inability to cope in the way she did in the community.

They discussed that long-term admission had not been beneficial for Abbigail in the past and therefore her care in the community would be increased.

Abbigail stated that she did not wish to "go on anymore" and felt "fed up of feeling up and down" and "being with thoughts". She reported to have felt she had lived her life and was hopeless. She was able to demonstrate some future orientation in relation to her want to have scan on her brain following incidents where she banged her head in hospital. She also expressed that she wanted to live independently with a dog. She expressed ongoing suicidal thoughts but did not express plans to end her life. She also indicated that she was unsure if she could maintain her safety.

Abbigail discussed her alcohol consumption and was offered education around the use of alcohol, which she was aware of. She reported to have drunk alcohol to “block feelings” and she informed her level of intake had increased since the breakup of relationship with her ex-partner. She declined a referral to Open Road to support with her alcohol use. She demonstrated an awareness that her alcohol use increased her impulsivity and negatively impacted on her mood, but did not wish to consider a reduction in volume at the time.

They discussed psychological intervention, to which Abbigail declined and did not wish to be referred when offered. The process of psychological input was explained to Abbigail and she was strongly advised to consider a referral.

Abbigail declined help and support and was unable to identify factors that she felt helpful and supportive.

Abbigail's care coordinator informed the accommodation staff of the content of their visit and the care coordinator planned to visit the next two consecutive days. In addition, they would request a medical review and it was noted that she had requested a brain scan and was concerned about long-term damage. Abbigail showed her care coordinator a letter she had received from her last medical review under Home First and felt some of the information was incorrect and requested for this to be changed; her care coordinator agreed to email the author of the letter about the content. Abbigail was aware of her crisis plan.

Abbigail's care was discussed in the Specialist Psychosis Team MDT meeting. It was agreed that they would increase the frequency of contact as an alternative to a referral to Home First as this would provide Abbigail with more consistency with staff members she was familiar with in the team. They planned to review this plan again as a team on 17th February.

Abbigail was contacted by her care coordinator over the phone. Abbigail was offered a visit the following morning, she requested the afternoon to which she initially declined but then accepted. They agreed a time of 10:00hours.

At 18:15hours, Galleywood Ward staff member attempted to contact Abbigail to provide follow up after discharge, however there was no answer so a voicemail was left...”

198. Under the title ‘Summary of progress notes’ Dr [A]’s report continues to state:

“...16.02.22 Lisa spoke with Abby’s friend [I/S] who has not heard anything from Abby and her other friend [I/S] who said she last spoke with Abby at 4pm yesterday and Abby had said to her that she “is not okay” “has reached her limit” and “is sorry”. [I/S] then informed Pavilion Court staff of this information...”

199. An extract from Abbi’s pink ‘Personal Assistant’ Filofax book states:

Week commencing 24.01.2022

“...please let me die I want to jump The urge to jump was so strong I couldn’t control it I don’t want to live anymore...”

My understanding of Abbi’s final admission in Galleywood Ward before she died

200. Some days later Galleywood ward in the Linden Centre re-opened after the pre-requisite length of time post Covid and Abbi was transferred back there. Whilst in the previous hospital Abbi had given permission for me to be told what was happening with her care, when she was transferred back to Galleywood she apparently withdrew that consent. Abbi said she had to travel back to Galleywood in a “cage” on her own.

201. I continued to ring her whilst she was an in-patient but she answered my calls less and less. She regularly posted on Facebook about the “state of the ward” and posted “help me” messages. She even videoed her room and explained in the video that she couldn’t get changed because there were no coverings on the windows. The room was bare except for a chair and a hospital style plastic mattress on a raised platform.
202. To my surprise, as mentioned above, the psychiatrist from Galleywood Dr [B] contacted me during this admission in order to ask me to tell him about Abbi - I was so impressed! I remember thanking him and telling him how important it was to have an understanding of an individual's entire life in order to treat them appropriately and that a holistic assessment was so important. I told Dr [B] that I didn’t think sectioning Abbi ever helped because she was stuck on a hamster wheel and was becoming institutionalised – I said that what she really needed was a full care plan which actually did deliver care! I suggested (with respect) that he contact a unit I knew of in the UK who treats people with comorbidities such as learning difficulties/mental health/autism and ask them how they facilitate their discharge planning in order to support an individual to achieve a safe and sustained discharge in the community.
203. He asked me to send him all of the assessments that had been done on Abbi which showed she had learning difficulties and autism so that he could decide the best way forward. He also asked for the details of the unit. I spent half a day in the loft finding all these assessments, scanning them over to him and sending him details of the unit - but he didn’t even acknowledge my email. A couple of days later I tried ringing to ask if he had received the information I sent him and I was told he was on ward round and would call me back - but he never did call me back. I think it was the next day when Abbi sent me a text which said, “hey mum, I’m on my way home”. At no point did the ward share with me that they were considering discharging Abbi, and on the day of discharge they did not inform me that they had simply put her in a taxi and returned her to exactly the same circumstances that she had faced prior to admission. I would not have known but for receiving Abbi’s text.
204. I found out since, that Abbi had told her friends that soon before she was discharged, she attempted to take her life so badly on the ward that the staff had to bring the resus kit over. I cannot understand, if that is true, how they could have discharged her with such inappropriate support, and discharged her back to the same circumstances prior to admission. I have also since found out that Abbi explicitly shared with staff, mere days prior to discharge, that she planned to take her life once back in her flat. They still went ahead and effected discharge. How much belief did they have that she would be okay? This point was put to Dr [Q] during the Inquest and my impression was that he became very angry.
205. Abbi posted many videos on her TikTok profile, which of course I couldn’t see at the time because I’m not on TikTok. Having seen them after Abbi’s death, I can say that they are all incredibly difficult to watch and show how upset she was. Abbi very rarely showed emotion and was an exceptionally passive person. Making these videos where she is so distressed makes it all the harder to watch.
206. There is one video where she is crying absolutely hysterically and talking to the camera - but one cannot hear what she is saying because of the sad music playing over the top - it is very, very difficult to watch. I tried everything to try and understand what she was saying, including getting a lip reader to translate. Later on, I found the version of the video which was unedited, and essentially Abbi had been “told off” for helping another patient. I very rarely saw Abbi distressed, never had I seen her like that and I think it was the straw that broke the camel’s back- I think this is when she made the decision to take her life. I had only ever seen a very passive Abbi.

207. There was another video of Abbi reading a care plan on the day she was discharged. There is a section in it where it is quite obvious that the hospital (EPUT) have cut-and-paste details from somebody else's care plan into Abbi's - because the information does not relate to her at all. The Trust have been accused of doing this in the past and have agreed that they did so - but the Trust stated that this practice had now been stopped! Quite clearly it hadn't! The video shows her level of confusion at being (in her view) accused of spitting and growling at people, attacking her family, of defecating in her kitchen - all things that she had not done! Perhaps this too is one of the things that pushed her over the edge.
208. That day she killed herself, which was the day after her discharge, she left her flat at 4 o'clock in the afternoon and was seen on CCTV. She had spoken to her Care Coordinator in the morning and talked about being able to have a dog one day. The Care Coordinator was the last person to see her alive at about midday. Abbi was next seen on CCTV at 5 o'clock going into a local park - she wasn't seen again until about 11 pm when a man coming home from work found her body in the park. He attempted to resuscitate her and called for help. The police tried to resuscitate her and then the paramedics tried to resuscitate her. They worked on her for about half an hour / an hour but pronounced her dead at quarter past midnight.
209. The wardens at her flat were supposed to tell Abbi when to take her medication because she wasn't trusted to take it independently. They should have prompted her at 5pm. Apparently when they didn't get an answer from her, the warden on call advised another warden but they chose to do nothing. At some point, they entered Abbi's flat – although I only became aware of this during Abbi's Inquest. They saw her phone, which I believe is a huge red flag with someone like Abbi, and yet they chose to not alert emergency services or even call me. The impression given to me has been that the wardens reported Abbi missing with no prompting, but it was Abbi's friend who called the wardens the next day at 9am. She asked them to check Abbi's flat because she was worried about her. The wardens state that they alerted Police - but that is only because Abbi's friend alerted them.
210. It is my understanding that Abbi was in Basildon ward on 2-1 observations, yet after being transferred back to Galleywood ward on 3rd February, she was deemed fit for discharge approximately 10 days later.
211. As previously mentioned, Abbi put up many social media posts / videos about Galleywood during her final stay there.
212. Around the time I was preparing for my commemorative evidence for the Lampard Inquiry, I was informed that the videos of Abbi were not appropriate to be shown at that stage – **I therefore expect the Inquiry to allow me to show the following videos during my oral evidence:**
- a. Video of Abbigail 9 February 2022
Abbigail took this video at 23:53pm explaining the failings of Galleywood Ward. Abbigail details how she had to support other patients on the ward whilst the staff were not doing anything to support them.
 - b. Video of Abbigail on 10 February 2022
Abbigail took this video at 12:09am on 10 February 2022. Abbigail explains in this video how Galleywood Ward 'has gone downhill so much', and how she is 'finished with life' and has 'got nothing left'.
 - c. Video of Abbigail on 10 February 2022

Abbigail is visibly distressed in this video for being told off for supporting another patient, 'I was trying to support someone because the staff don't do anything, and I got told off'. This video was taken by Abbigail at 09:45am on 10th February 2022.

With regards to what Abbi is saying in this video, I understand that an exhibit to Dr Karale's witness statement [MK2-152] Patient 'My Care, My Safety Plan' includes the phrasing "...Something small and kind I can do for someone else is & someone I can help with a small act of kindness is..." as part of a care / safety plan. Whilst giving oral evidence in May 2025, Dr Karale was unable to say when this practice started but he mentioned that since 2012 in his position as a medical director for SEPT, "... some form of information was provided to patients...". My understanding is that the care plan approach was in place at that time.

Why was Abbi so told off for supporting another patient when this patient plan encourages thought about what acts of kindness one can do for others?

d. Video of Abbigail on 13 February 2022

This video was recorded by Abbigail at 12:07am on the 13th February 2022 whilst in Galleywood Ward. Abbigail is showing her room, which Abbigail details left her with no privacy as if she wanted to get changed she had to turn her light off 'so people do not see through the windows'. This is the day prior to Abbi's discharge, and yet it is visible in the video that her room is stripped (curtains / bedding etc), due to her acute ligature risk. Despite this the responsible clinician decided discharge the next day. This beggars belief. She cannot be trusted in hospital to have bedding or curtains, but she can be trusted at home, alone and with no support?

e. Video of Abbigail on 13 February 2022

This video taken on 13th February at 15:25 is really important. It was recorded whilst she was under section the day prior to her discharge and demonstrates quite clearly that her plan was to take her life, so making a mockery of the decision to discharge her because apparently "she was no longer a threat to herself". She is saying she has no option but to take her life, it clearly demonstrates what a bad place she was in, and yet she was discharged the following day.

f. Video of Abbigail on 14th February 2022

This video was recorded at 16:45pm, the day prior to Abbigail taking her own life. This video shows Abbigail reading a 'care review/care plan' letter from Essex Partnership University NHS Foundation trust, dated 27 January 2022. Abbi is clearly confused as to why she is "being accused" of things she knows she didn't do. We now know, of course, that this was part of someone else's history of admission / care plan. As detailed above in my statement, section 8.11.17.4 of Dr [A]'s report referenced Abbi showing this letter and appearing to be very distressed by it.

213. Other evidence which shows her state of mind around the time she died includes:

- Abbi left a very clear and obvious suicide note – I have reproduced this towards the end of my statement. This was saved on her laptop and had been drafted initially on 14th February, the day she was discharged, and edited on 15th.
- WhatsApp messages sent between Abbi and one of her friends, which clearly show that on the day prior to her discharge, she had again actively tried to take her life - so how they could discharge her just 24 hours later remains a mystery.
- Dr [A] includes the following with regards to the witness statement of [I/S]

"Within the Witness Statement of [redacted] [redacted] (Mental Health Nurse), dated 3 March 2023, it is noted:

'Abbi phoned me in my personal capacity on the date of her discharge.'

"I asked how she had been doing, and Abbi went on to tell me that she has tied a ligature two days previously, and she said that they had to bring the resus bag to her."

"She explained to me that she was happy to be discharged although she sounded reluctant and said that she was upset because she didn't feel that she got the support she needed as she still felt in the same position as when she went in'."

- I also found google searches (15 February 2022) on 'dark spirits' which I can provide the Inquiry with. The research pieces on dark spirits, are what she was looking at on the day that she set out to take her own life and again, demonstrate her internal struggle that was not recognised by the unit at the time of discharge.

214. If it is true that Abbi attempted to take her life just prior to discharge such that the resus trolley was wheeled over, I find it hard to believe that staff would have had no insight into what might happen when she was discharged. It leaves me wondering whether it was the case that they were fed up with her. No one listened to me and no one tried to help her. No one engaged with other services to try and effect the safe, sustained and successful discharge that I always harped on about. Abbi was simply too difficult for them to manage, but that is because no one truly tried to understand her.

215. With regards to events in 2022, Dr [redacted] A states the following in the '**OPINION**' section of his report:

"...10.18.1. I do not express concerns regarding the management of Abbigail Smith's presentation following her admission to Accident and Emergency on 24 January 2022 and fully support the subsequent decision to admit Abbigail Smith to hospital. However, I refer the reader to my extensive concerns that national policy was not followed, that there was no consideration of the relevance of her autism (either in the context of the overall diagnostic formulation or the subsequent care treatment afforded to her), that she continued to express active suicidal ideation with a clear plan upon discharge and that the formulation of her presentation and behaviour as being a manifestation of EUPD alone (and I refer the reader again to my commentary as to the diagnostic formulation) wholly failed to take into account the impact of her history of trauma, her elevated actuarial (static) and dynamic risks for suicide (either through design or accident, and I make no judgement as to the same) or the impact of her autism and the concept of monotropism; I have already also commented upon the fact that she was to return to the exact same situation (both living and socially) as per the pre-admission period and – in essence – that nothing had changed (and – thus – she would likely be re-traumatised).

10.18.2. I would also note the likely impact of admission and the increased cognitive and sensory 'load' placed upon Abbigail Smith within the in-patient setting and – in my opinion and experience – that she would have processed this in the period post-discharge and that this would have further contributed to a lowering of her mood and – thus – an elevation of her risk that, had her autism been recognised and appropriately formulated, could have been care planned...

10.19.1. ...there was inadequate and inappropriate discharge planning from the Linden Centre that concluded with Abbigail Smith's discharge on 14 February 2022...

10.22.2. The persistent use of incorrect information regarding her presentation, as summarised within the progress note entry dated 14 February 2022, would not have altered the detention status or criteria for Abbigail Smith but, in my opinion, erroneously contributes to a 'view' or 'picture' of her that is reinforced by the focus upon her sole diagnosis being that of EUPD

10.22.3. I would reiterate my concerns as to Abbigail Smith's autism not being recorded or addressed and would view this as both a clinical failing but also a systemic failing in terms of how the Trust would 'digitally flag' an individual who is autistic, given that such information mandatorily feeds into the relevant submission that are required to NHSE England (Assuring Transformation and Mental Health Services Data Sets).

10.22.4. I would reiterate my concern as to the wholesale lack of any reference to relevant procedures related to the DSR and CTR processes, both at a clinical and apparent system level.

10.22.5. In terms of the Trust response to Abbigail Smith's autism, as set out within the PSII, I replicate this as follows:

10.22.5.1. 'In relation to Abbigail's care and risk management plans being aligned with her diagnosis of autism; the Trust has adopted the Learning Disability Standards published by NHS England to help NHS organisations measure the quality of care provided to patients with learning disability and autism to ensure reasonable adjustments and have questions included within Mental Health Assessments about autism, learning disability and physical disability in order to inform personalised care planning and crisis plans'.

10.22.5.2. The Learning Disability Standards were published by NHS England in 2019 as part of NHS Long term plan to assist NHS organisations in planning for improvements to all NHS funded care. These standards will be applied to these services from 2023/2024

10.22.5.3. In addition, as of 1 July 2022, the CQC updated their statutory guidance to mandate autism and learning disability training for staff appropriate for their role. The position at present is that this is touched upon within existing Positive Cultures online training which is part of induction and now covers awareness around learning disability and autism.

10.22.5.4. In the near future, EPUT will offer two tier training. Tier one training will involve 90 minute e-learning with a workbook and a one hour online drop-in session facilitated by a trio of two experts by experience and one expert trainer, which is currently being recruited.

10.22.5.5. Tier two training will be available to all staff with a responsibility for providing care and support to people with a learning disability and/or autism. This will include aspects of two one training, with an additional face to face training date, delivered by an experienced and expert trainer'.

10.22.6. I would question why, given that the Learning Disability Improvement Standards were prominent within the NHS Long Term Plan and included in the NHS standard contract in 2019/20, it has taken until 2023/2024 for the Trust to apply these standards to services.

10.22.7. I would further question the suitability of training wherein autism is 'touched upon', given the legislative framework set out within Section 181 of the Health and Care Act (2022) that 'require service providers to ensure that each person working for the purpose of the regulated activities carried on by them receives training on learning disability and autism which is appropriate to the person's role'; I have already noted the frequency with which autistic people are referred to community and in-patient services (with some estimates that 15 – 20% of all in-patients have a neurodevelopmental disorder), the relevant framework as set out within the Oliver McGowan Mandatory Training (as I would further query why the Trust is not using this training given it is the recommended national modality) and the Autism Core Capability Framework and ancillary guidance that would suggest that all clinical staff would require Tier 2

training as a minimum and that a substantive number of clinical staff require Tier 3 training (as offered via the National Autism Training Programme that is commissioned via NHS England Workforce, Education and Training).

10.22.8. I would additionally suggest that it would be beneficial for the Trust to set out its position regarding staff training, the appropriate recording of diagnosis and the mechanisms by which adherence to national policy will be assured...”

216. As highlighted previously, Dr [A]’s report states (at the end of his report):

“...10.23.1. I believe that the failure to record and clinically consider Abbigail Smith’s autism diagnosis, to make appropriate reasonable adjustments, for staff to be appropriately trained and for her needs to be formulated accordingly, particularly in the context of risk assessment, fundamentally contributed to the death of Abbigail Smith...”

217. I am strongly of the view that the Inquiry should be made aware of the concerns which staff looking after Abbi had with regards to discharging her (for the final time). Dr [A]’s report contains the following from the witness statement, dated 24.01.2023, of [O] (Abbi’s care coordinator):

“...8.11.2. ... worked with Abbi for 11 months until she sadly passed away on 15 February 2022. Abbi had **diagnoses of Simple Schizophrenia, Borderline Learning Disability and Borderline Personality Disorder...**

8.11.5. ‘On 26 January 2022, I can see from reviewing the notes, that The Home Treatment team attempted to review Abbi however due to her being intoxicated, they rescheduled their review to the following day (27 January 2022). In my absence, The Duty team at The Gables supported Abbi. Clinical Lead [I/S] and Community Mental Health Nurse [I/S] attended Pavillion Court where Abbi and became involved with a series of incidents, which occurred outside of Abbi’s supported accommodation which is in very close proximity to The Gables base. According to their case notes, Abbi was presenting as a serious risk to herself, she was intoxicated and had physically hurt herself. The Police and an Ambulance attended to take Abbi safely to hospital to be assessed physically and to have a review of her mental health ... Mental Health Liaison Team and The Home Treatment Team for the purpose of a Gatekeeping Assessment reviewed Abbi jointly. The professionals who assessed Abbi made the decision to refer Abbi for a Mental Health Act Assessment.

8.11.6. Abbi was admitted to Basildon Mental Health Unit on 27 January 2021. I had email correspondence with an assistant psychologist who was working between the wards and community mental health teams, in an attempt to improve communication between both ... asked if I was able to join the ward review which was scheduled for the next week and asked that my details be passed on to the ward staff to organise my attendance at the ward review. However I did not receive any invites from the ward to attend any ward reviews despite asking different professionals on a few occasions.

8.11.7. Whilst Abbi was an inpatient, she called me on 1 February 2022. Abbi informed me that since her admission, she had head banged quite severely and was reviewed by a Doctor on the ward due to a large swelling on her forehead ... asked if I could ‘get her out of here’ and to ‘tell the ward staff to let her go’. I informed Abbi that her discharge would be an MDT (Multidisciplinary Team) decision and that I had requested to attend her ward review. We discussed that if Abbi was self-harming then it was unlikely that she would be discharged from hospital. Abbi very explicitly informed me that she would end her life if she were to be discharged from hospital...

8.11.8. Abbi was transferred to Galleywood Ward at The Linden Centre, on 3 February 2022, so that she was within our locality area and nearer to her home address.

8.11.9. On 4 February 2022, I had a telephone conversation with Dr [Q] (Consultant Psychiatrist) on Galleywood Ward. Dr [Q] informed me of Abbi's transfer to his ward ... reported that he wanted it to be a short admission, as he did not feel as though hospital admission would be beneficial or therapeutic for Abbi. I wrote within my clinical note that historically long admissions had included an increase in self-harming behaviours such as ligature and head banging and hence I agreed that hospital admissions had not always been beneficial in the sense of self-harming behaviours increasing'.

8.11.10. Dr [Q] stated that although Abbi was expressing suicidal thoughts in hospital and for when she was to be discharge into the community, he stated that there was evidence of future planning. I expressed that I was concerned about the risk of accidental death in hospital, as well as this increasing in the community upon discharge ... could not comment on Abbi's intent or future planning as there had not been any evidence of future planning to me when I spoke with her on 1 February 2022 ... raised my concerns regarding Abbi's discharge and requested if she were to be discharged, the safe thing would be to ensure that the Home Treatment Team were able to provide support for Abbi ... expressed that with the right level of input and support from services in the community upon discharge (Home Treatment and Stepped up care from The Gables) and only with safety reassurances from Abbi (no suicidal ideation and or intent expressed) then I would support Abbi's discharge as I knew that long admissions were historically not beneficial for Abbi. However, Abbi was expressing active suicidal ideation with active intent to end her life at that time and hence I felt as though her risks would were the most safely and appropriately managed within an inpatient clinical setting at that time. I expressed to Dr [Q] that the Home Treatment Team had refused to see Abbi prior to admission when she was intoxicated and hence this could also impact Abbi's support at discharge. At the end of the conversation, I arranged to attend the ward review the following week

8.11.11. I received an email from [I/S] (Assistant Clinical Psychologist) who had been working to improve communication between inpatient and community settings. Assistant

clin. psychol.

informed me that Abbi's case was discussed within the MDT on Galleywood Ward on 8 February 2022. The outcome of these discussions were that Abbi had witnessed 2 inpatient suicides and that her Mum did not want her to be on the ward and said she would like Abbi to be supported in the community. Psychology asked if Abbi had been offered transitional psychology, they were aware that Abbi had DBT (Dialectical Behavioural Therapy) before. They were looking for a type of therapy that would be suitable for Abbi. The last point on the list was informing me that there was a discharge planning meeting scheduled for 9 February 2022

8.11.12. I attended Abbi's ward review on 9 February 2022 via Microsoft Teams ... informed the MDT that Abbi had informed me on 1 February 2022 and had informed ward staff the day prior to this meeting on 8 February 2021, following reading the ward's clinical notes, that she would end her life if she were to be discharged from the ward and had asked that staff to not tell Dr [Q] ... made sure that Dr [Q] knew this information and Abbi's intentions. Dr [Q] was aware of this and we discussed this. At the time, I was concerned about Abbi being discharged with the increasing risk of suicidal ideation and expressed intent to end her life. Abbi then entered the ward review and Dr [Q] informed Abbi that he planned to discharge her on 14 February 2022...

8.11.13. 'I had initially agreed to discuss with the Home Treatment Team to request their support upon discharge however upon discussing this within The Gables MDT, I informed Dr [Q] that it was the ward's role to refer to the Home Treatment Team to facilitate an assessment prior to discharge to determine their input ... raised my concerns regarding discharge without the support of the Home Treatment Team and the risk of death by misadventure ... felt that due to the high level of risk Abbi was presenting with, that increased support and monitoring from the Home Treatment Team, as well as The Gables, would help to support Abbi post discharge. Following the ward review, I immediately discussed my concerns with my Team Manager

[I/S] and Clinical Lead [I/S] regarding Abbi being discharged so imminently with high expressed risk and intent of suicide. I expressed that my concerns regarding Abbi's high risk to herself at that time and this increasing post discharge and my feelings that discharge at this time felt unsafe, as expressed to the inpatient team.

8.11.14. On 14 February 2022, I sent an email to Dr [Q] to inform him that I had not received an invite to attend Abbi's ward review that morning and requested that an invite be sent so that I could attend and be involved in the discharge planning. I received an email from [I/S] Staff Nurse, on Galleywood Ward later that day to inform me that Abbi was seen within ward review and she was to be discharged that day. Alice reported that she had a discussion with the Home Treatment Team and they had advised that 'The Care Coordinator would need to complete the 48 hour follow up and if there are any concerns you can then make a referral to them'. I replied to this email and expressed that I had requested and wanted to be involved within the ward review, as Abbi's Care Coordinator, however did not receive an invite to this ... also expressed via email that I had wanted the Home Treatment Team to be involved for the purpose of stepped up care in the community with The Gables Specialist Mental Health team, for increased monitoring and support due to increased risk to herself upon discharge, not for the purpose of the 48 hour follow up...

8.11.15. I made immediate telephone contact with Abbi on 14 February 2022 knowing that this is likely to be a high risk time for Abbi due to her thoughts and expressions regarding her suicidal thoughts and intent whilst an inpatient and hence this risk increasing once discharged into the community. Abbi informed me that she needed to do a lot of cleaning and tidying of her flat ... informed me that [I/S] a staff member from Pavillion Court whom she had a good rapport with, was working on that day and was going to support her. She informed me that she was currently with [I/S] now having a coffee and a chat. I arranged with Abbi to come and see her the following day for the purpose of 48 hour follow up post discharge. Abbi informed me that she would ensure that she would be up for the appointment and consented for a student nurse to be present with me'

8.11.16. 'I called Abbi's mobile phone before her appointment, to check that she was awake and ready for her appointment with myself. Abbi requested that I came a little later as she had to go to the shop to buy some tobacco and so we attended a little later. I attended Abbi's home address on 15 February 2022 for the purpose of completing a 48 hour follow up post discharge with student nurse [I/S] Abbi ... was tearful at times. ... Abbi expressed suicidal ideation, which appeared to be ongoing and potentially chronic in nature with no plans to end her life but indicated that she could not ensure her safety at that time. We discussed her hospital admission and Abbi reported that she had felt 'abandoned by the hospital for discharging her so soon'. I mentioned that the ward had felt that the admission was counterproductive for her due to an escalation in her self-harming behaviours. We discussed how long term hospital admission had not been helpful for Abbi in the past. I explained that the plan was to step up her care in the community from ourselves to offer some more intensive support. Abbi reported that she 'did not want to go on any more' and felt 'fed up of being down and with her thoughts' and that she had 'lived her life now' ... appeared hopeless however on occasion throughout the appointment, Abbi showed future orientation such as requesting me to organise a scan of her head following her head banging during hospital admission and discussing her plans to live independently and to get a dog in the future ... did not express any firm plans to end her life however Abbi did not give firm verbal reassurances for her safety. We discussed Abbi's alcohol intake and Abbi expressed that she drinks to 'block out how she is feeling'. Abbi declined a referral to Open Road (local Drug and Alcohol service) at the time of the appointment ... had awareness that her alcohol intake increased her impulsivity and negatively impacted her mood but did not want to cut down on this at this time ... declined a referral to our psychology team during the appointment as she felt that it would not be helpful.

8.11.17. *The plan following this appointment...*

8.11.17.2. *To step up Abbi's care within our team, arranged for duty to visit the following day (16 February 2022). Abbi had appeared to respond well to my Duty colleagues and stepped up care a few months before.*

8.11.17.3. *To arrange a medical review. Abbi also requested a brain scan due to head banging as she was worried that she had done some long term damage and hence appeared to express a concern for her wellbeing.*

8.11.17.4. *During the appointment Abbi had shown me a letter which was sent to her that she had received following discharge home. Abbi was concerned as the letter appeared to have incorrect information about Abbi within it ... appeared to be very distressed about this letter and I informed her that I would request that the doctor who wrote this change it'.*

8.11.17.5. *'This letter was from when Abbi was reviewed by phone by Dr [N] from the Home Treatment Team on 25 January 2022....*

8.11.18. *Following this visit, I had an MDT discussion with Duty Team at The Gables to discuss how it was best to support Abbi during this time with her current mental state and risks following my appointment with her. We discussed all options appropriate to Abbi to manage her current risk and mental state ... discussed that Abbi's risks appeared to be ongoing in regards to suicidal thoughts. I felt reassured that Abbi would seek help and support if she was struggling with her mental health and was aware of how to do so, as evidenced historically through the clinical notes.*

8.11.19. *A Mental Health Act referral was discussed however we felt that Abbi would not necessarily benefit from hospital admission after she had only just been reviewed and discharged the day prior, with the same presentation, by a Consultant Psychiatrist. It was felt that hospital admission ideally should be avoided where possible due to evidence that hospital admission escalates Abbi's selfharming behaviours and she had previously had negative experiences of being an inpatient. Abbi had also agreed with this previously. It was also likely that if a Mental Health Act Assessment was clinically indicated, that it might take some days before this assessment has taken place and a bed becomes available and hence this would not manage Abbi's risk promptly."*

8.11.20. *A referral to the Home Treatment Team was discussed and it was felt as though our Duty team could manage Abbi's mental state as effectively, with a more consistent and familiar approach as Abbi knew the team at The Gables well and the team knew Abbi well. The Gables Duty Team could provide the same level of stepped up care as the Home Treatment team and there were concerns that the Home Treatment Team would not see Abbi if she was under the influence of alcohol whereas the Gables Duty Team would still see Abbi if intoxicated. It is also likely that the Home Treatment Team may have requested a period of input and stepped up care from The Gables before they would accept a referral, to justify the need for support from them.*

8.11.21. *It was felt after discussing with MDT following this visit, that stepped up care from The Duty Team at The Gables would be most beneficial to Abbi at this time due to the consistent approach that could be provided by the same team...*

8.11.22. *At the time of Abbi's death, Abbi was residing in Intensive Enablement supported accommodation. Whilst she was receiving support with regards to her medication concordance it is unclear what other daily support Abbi was in receipt of. 'Discussions had been started with Abbi, around a move on to independent living with an additional care package, however these discussions were in the very early exploratory stage.*

8.11.24. ... **Abbi's mental state and risks escalated to a point where I believed that Abbi was safer in an inpatient setting than in the community. Hence my concerns that Abbi was not ready for discharge on 14 February 2022 and that the discharge was unsafe.**

8.11.25. *For the most part of our work together, Abbi experienced suicidal thoughts and thoughts to harm herself. The thoughts appeared to be long term and mostly without any active plans or intentions to end her life. However just before and during hospital admission, Abbi began to express this with strong intent and verbally expressed her intention to end her life upon discharge from hospital. This concerned me and hence I raised my concerns to Dr [Q] within the ward's MDT, to my managers and our MDT as I was extremely concerned about there being an unsafe discharge'...*

(emphasis added)

218. In addition, Dr [A] quotes from a witness statement of [O] dated 5 December 2023, as follows:

"...8.16.3. On 09/02/22, I attended Abbi's ward review via Microsoft Teams within the MDT meeting on Galleywood Ward. For the purpose of sharing information with the ward MDT, I shared that Abbi had informed me via telephone on 01/02/22 when she was at Basildon Mental Health Unit that she was having suicidal thoughts and intentions to end her life if she were discharged. And that I had read within the clinical notes that she had also disclosed this to ward staff on 08/02/22. The ward MDT were aware of this and it was discussed within the MDT. Abbi was seen within the review, a discharge date was set for 14/02/22, and a plan was made to request input for a supported discharge from The Home Treatment Team. During this ward review, I agreed to Abbi's discharge from the ward on the premise that there was support from the Home Treatment Team, that Abbi was able to give reassurance for her safety and was expressing future planning upon discharge from the ward. I acknowledge that the decision to discharge a patient from an inpatient ward is ultimately the decision of the Responsible Clinician and the MDT within the ward. Following the ward review, I discussed with the Clinical Manager and Clinical Lead at The Gables regarding my apprehension about the suicidal ideation that Abbi had mentioned whilst on the ward and that this risk could potentially increase post discharge from the ward'..."

Patient Safety Incident Investigation report

219. This report was the result of the Trust's investigation into Abbi's death.

220. There were 2 versions of this report which is further explained below. Version 2 is 73 pages long and therefore I felt that the simplest way to address the report is to bring to the Inquiry's attention some of the points which Dr [A] raised in his report regarding the PSII. Dr [A] states:

"...9.1. Within the Amended Patient Safety Incident Investigation (PSII) Report, dated 30 November 2023, an overview is provided as to Abbigail Smith's history of admissions to in-patient psychiatric care and the involvement of Essex Partnership University Trust Community Mental Health Services.

9.2. Whilst the PSII Report will not be included in its entirety, the Summary of Key Findings are noted as follows...

'...9.2.2. Several assessments were conducted for Abbigail's learning disability and autism whilst she was a young child and throughout her early admissions which concluded these diagnoses. The assessment documents were stored within the clinical records system however were not in a place which could easily be located or not collated in a way which would inform care delivery'

9.2.3. *'At the time of her last admission and in the more recent past, Abbigail's primary need was determined as being her mental health, and consultation with an Autism specialist may have assisted with the way in which her care was delivered. There would also have been benefit from assessing how her communication abilities would have impacted on her ongoing care.'*

9.2.4. *Abbigail had a number of incidents on the ward during her last admission, and verbalised thoughts to end her life. Understanding the triggers to each of the incidents, and an individualised management plan may have assisted. Abbigail's risk assessment did not contain information about the triggers to her risk and her needs, which may have supported staff with predicting riskier times for Abbigail.'*

9.2.5. *NICE guidance CG78 suggests that admission is for crises with significant risk to self or others that can't be managed in other services. Acute crises are generally considered of short in duration. Abbigail, her mum and her care team agreed that Abbigail would require a "short" crisis admission to Galleywood Ward. The term "short" has different meanings to all involved and more specific timeframes may have assisted with Abbigail's preparation for her discharge with the view that an original plan may be reviewed if felt she required more time as an inpatient. An 'expected date of discharge' would have assisted Abbigail and professionals involved in her care.'*

9.2.6. *Incorrect patient information had been scanned into Abbigail's records, which carried through into subsequent assessment details, specifically a Mental Health Act assessment. The inaccurate information was included within the initial referral to the AMHP Hub and subsequently considered in Abbigail's reason for a referral for a Mental Health Act assessment.'*

9.2.7. *The inaccurate information was shared with Abbigail in the form of a letter following her review under Home First, which caused her distress.'*

9.2.8. *Abbigail's mum emailed a ward Doctor documents and details of Abbigail's needs, however did not receive a response to the email and therefore there was no reassurance that her concerns had been acknowledged. Having a team email address for the ward, monitored by ward staff may have provided a timely response to Abbigail's mother.'*

9.2.9. *Abbigail's planning on the date of discharge did not involve key people in her care, such as her family, community team and accommodation staff. This would have allowed for a progress update during her admission to have been discussed, and an overview of her risk and needs following discharge.'*

9.2.10. *EPUT's Safeguarding Team were not consulted to provide support to clinicians*

[I/S]

9.2.11. *Several emails were shared between Abbigail's accommodation staff and care coordinator, however not all of them featured within the clinical records system...'*

...9.3. *The following findings have been established from the investigation, which relate to ECC:*

9.3.1. *'ECC had limited involvement with Abbigail during the period referenced within this report.'*

9.3.2. *Both Mental Health Act assessments were comprehensive in their approach and appropriate in their outcomes, listening to the views of Abbigail and her wider support systems.'*

9.3.3. At the time of review October 2022 by ECC, Abbigail's primary need was assessed as being her mental health and she was discharged from ECC with the view that her EPUT care team would continue with reviews.

9.3.4. When a patient has been identified as requiring review of needs, proactive steps should be taken to alert mental health services to ECC involvement and participation at ongoing inpatient reviews. If there is a known diagnosis of LD and/or autism Mental Health Services to alert and request ECC involvement and participation within the review'.

9.4 The following findings have been established from the investigation, which relate to Pavillion Court: ...

9.4.2. Pavilion Court is temporary accommodation, a move on service comprising six self-contained flats and a small staff office at one end of the building which enables the customer to work towards independent living. Abbigail's tenancy commenced in September 2019 and therefore her "move on" planning should have commenced; however as she underwent changes to her medication and she presented with fluctuating mood with a hospital admission, it was not felt appropriate to plan for her move...

9.4.5. On 16th February, staff arrived at the accommodation at 06:00 hours and Abbigail was not present. At 08:30 hours, Abbigail's friend telephoned staff to inform she had texted the day before that she had "reached my limit" and was "writing a note on my laptop..."

221. Dr A's report further states:

"...The PSII Report recommends the following as areas for improvement and safety actions for EPUT:

'...Safeguarding Policy at a Glance document to be collated with the Safeguarding Team and Lessons Team and issued across all services...

Discharge protocol to be reviewed, to incorporate when and how discharge planning takes place with family members, carers, support packages/accommodation and community care teams...

Task and Finish Group to be set up to define the requirements and content for inpatient welcome packs; which should include learning from this investigation...

Estimated Date of Discharge to be identified at the time of admission and communicated with the patient and those involved in their care. Pre-discharge meetings should be scheduled in advance, where appropriate'...

With regards to the actions that EPUT state have been undertaken following the death of Abbigail Smith, it is noted:

"...'Safeguarding: EPUT have updated the relevant safeguarding policies and the safeguarding team are liaising with the discharge coordinators who are supporting the team to ensure that any abuse identified during someone's ward admission is discussed and a specific plan is in place at the time of discharge to prevent further harm. [I/S] would therefore have been more prominently discussed as part of discharge planning.

...The safeguarding team now have a new person in post whose specific role is to lead on all high risk [I/S] cases. Although this case was not reported to MARAC (Multi Agency Risk Assessment Conference), the training and support they are providing to the ward will enhance the knowledge of the staff.

...As part of the sexual safety work being undertaken by the trust Trauma Informed Practice has been highlighted. This would support people like Abbigail [I/S]

[I/S]

...Record Keeping: A Task and Finish Group is currently active, which is focusing on scanning documents in to Paris, an EPUT clinical records system. This has been set up following a number of breaches which occurred in respect of scanning compliance. The Group meet fortnightly, and includes administrative staff, system staff, clinicians and corporate support services. There are a number of work streams within the group, and accuracy of scanning is included.

...In addition, a Trust-wide reminder of how emails which relate to a patient are to be visible in the clinical records system was shared in January's addition of 5 Key Messages.

...Post-Incident Management: Following an incident, a Datix incident report form would be completed. These have been reviewed as part of this investigation. In addition to this, the Trust have adopted an approach whereby ward staff meet for a safety huddle to discuss safety and quality concerns and successes in the 24 hours prior and challenges that require a management plan. The use of the huddles assists with the staff coming together, to speak about these topics and help formulate plans for the following 24 hours. The huddle will include patient specific incidents'

...Autism: In relation to Abbigail's care and risk management plans being aligned with her diagnosis of autism; the Trust has adopted the Learning Disability Standards published by NHS England to help NHS organisations measure the quality of care provided to patients with learning disability and autism to ensure reasonable adjustments and have questions included within Mental Health Assessments about autism, learning disability and physical disability in order to inform personalised care planning and crisis plans. The Learning Disability Standards were published by NHS England in 2019 as part of NHS Long term plan to assist NHS organisations in planning for improvements to all NHS funded care. These standards will be applied to these services from 2023/2024.

...In addition, as of 1 July 2022, the CQC updated their statutory guidance to mandate autism and learning disability training for staff appropriate for their role. The position at present is that this is touched upon within existing Positive Cultures online training which is part of induction and now covers awareness around learning disability and autism.

...In the near future, EPUT will offer two tier training. Tier one training will involve 90 minute e-learning with a workbook and a one hour online drop-in session facilitated by a trio of two experts by experience and one expert trainer, which is currently being recruited.

...Tier two training will be available to all staff with a responsibility for providing care and support to people with a learning disability and/or autism. This will include aspects of two one training, with an additional face to face training date, delivered by an experienced and expert trainer.

...Care Planning: Goal focused care planning is being implemented in EPUT in Spring 2023. Training will be available, as the care plan template will alter and the expectation of staff members to complete a care plan will be patient and goal focused. This may also support with key information from other sources, such as diagnostic and psychology

reports, being included within one platform so this can remain at the centre of the patient's care journey.

...The following areas for improvement and safety actions for ECC have been developed: When a patient has been identified as requiring review of needs, proactive steps should be taken to alert mental health services to ECC involvement and participation at ongoing inpatient reviews.

...The following areas for improvement and safety actions for Pavilion Court have been developed: Missing Person's guidance to be reviewed, to incorporate a person-centred approach to reporting a customer as a missing person which is not solely based on the length of time they have been missing, but on knowing the customer, their needs and risks..."

(Emphasis added)

222. With regards to further extracts from the PSII report, Dr **A**'s report further states:

"...9.7. Within the body of the report, there are **'key questions from the patient/family/carers answered'**, with the following specifically noted:

...9.7.9 Why was Abbigail's Section under the MHA not right?

9.7.10. 'Following Mum's review of the report, the authors have revisited the question shared previously and consider this to be in relation to the information included within the letter shared with Abbigail containing the outcome of the MHA assessment. It has been acknowledged within the findings of the report that the information within the letter sent to Abbigail that incorrect information had been scanned into the clinical records system, which in turn had carried through into her Mental Health Act assessment. The inaccurate information was included within the initial referral to the AMHP Hub and subsequently considered in Abbigail's reason for a referral for a Mental Health Act assessment. The investigation has not concluded that this led to the wrong powers of the Mental Health Act being applied'.

9.7.11. Why were we not involved in care and discharge planning? I emailed a Doctor on the ward and I didn't get a response.

9.7.12. 'The investigation has found that you, your family and Abbigail's accommodation staff were not consulted as part of discharge planning and improvements are required.

9.7.13. The Doctor you shared information with via email confirmed they had received this, and had forwarded to their colleagues within Galleywood Ward. The investigators would like to extend apologies that you did not receive an email response, given the nature of the information you shared and the hope this provided that you were being listened to.

9.7.14 The information you shared was considered within planning, however a decision was made that Abbigail did not require admission to an autism or learning disability setting, because clinicians involved in her care assessed that her primary need was her mental health, in particular her Emotionally Unstable Personality Disorder'.

9.8. Within the **System Engineering Initiative for Patient Safety (SEPITS)** Findings, it is noted:

9.8.1 **'Tools and Technology:** Abbigail's inpatient risk assessment was updated five times whilst she was on Galleywood Ward. The risk assessment document is

automated to include historic information; and provided detail dating back to 2020, however the risk assessment did not provide a summary of the risk in which she presented with and the triggers for this, considering the number of years she had been known to mental health services. Including Abbigail's previous triggers may have supported her when she was at risk and reduced the risk with her in times where she was distressed on the ward'

*...9.8.2. **Tasks:** During admission, Abbigail had several incidents:*

9.8.2.1. 27th January – head-banged

9.8.2.2. 1st February – ligatured

9.8.2.3. 2nd February – head-banged

9.8.2.4. 3rd February – head-banged

9.8.2.5. 4th February – ligatured and head-banged

9.8.2.6. 8th February – ligatured

9.8.2.7. 10th February – ligatured

9.8.3. Abbigail had also vocalised on discharge that she had thoughts to end her life. The use of patient de-briefs following incidents to understand the trigger, cause and future preventative measures may have allowed for a more accurate risk assessment and care planned discharge formulation.

*9.8.4. **Internal environment:** Abbigail had a diagnosis of emotionally unstable personality disorder, learning disability and autism spectrum disorder. At the time Abbigail was an inpatient, training was available to staff members, however this was not mandatory or monitored and therefore there was limited evidence as to the skills mental health nurses in inpatient services have when managing a range of diagnoses, symptoms, risks and other challenges. Abbigail's mum wished for her to be in an autism ward, however the clinical team felt that Abbigail's symptoms of personality disorder were causative to her admission and her autism was not her primary need. Additional training and having contact with autism experts within the Trust may have supported care planning and discharge planning. The autism contact would not have been with the view of diagnosis, as Abbigail had an established diagnosis; but this would have been for consult and support. EPUT have committed to making changes to autism training and support available for mental health clinicians.*

*9.8.5. **External environment** All staff involved in Abbigail's care agreed that she would not require a lengthy admission'..."*

223. With regards to the incidents recorded between 27 January and 10 February 2022 above in section 9.8.2 of Dr **A**'s report, I am confused as to why all of the incidents are not documented here. For example, page 68 of the PSII report states that on 11 February, "...Abbigail was observed to have a plastic knife and attempted to harm herself with it..."

224. With regards to the original PSII report, dated 27.03.2023, which was part of the Inquest bundle, I needed to make numerous corrections / comments – these are in the below table. The subsequent amended version of the PSII report is dated 30 November 2023. In my view I, as the bereaved mother, should not be in the position to have to identify and correct matters such as Abbi's age - how is this going to help me have faith and trust in the investigation? I would like the Inquiry to be aware of the multiple comments I had to make with regards to the original document which were as follows:

<i>Page in PSII</i>	<i>Comment</i>
5	Abbigail was 26 years old, not 24 as stated
5	Did not overdose at the age of 16. It was 2015 when she was 20 and overdosed
6	Abbigail died within 36 hrs of discharge, not 72 hours
8	My understanding is that it was Abbi's friend who notified Pavillion Court on the morning of the 16th and it was only then that they entered her flat and reported her missing.
15	Borderline/mild Learning Disability – this disagreed with Neurodevelopmental and Cognitive assessment report from 2010/2011 of Abbi being on 0.5 centile for verbal comprehension and 2nd centile for full scale IQ.
15	I was advised that Learning Disability team and MH team had not met and discussed Abbi together, actually, MH team apparently had no idea LD team had gone out to see Abbi when I spoke to them
15	How is it concluded that Abbi was not actively suicidal when elsewhere in the document (pg 30, 61 and 68) it notes her ligaturing twice in 2 days when in hospital prior to discharge and sharing that she had a plan to take her life when discharged?
16	Pavillion Court did not appear to provide support pro-actively as when I spoke with Abbi numerous times daily, there could be many days with no contact at all. Occasionally Abbi would pop to them for a cup of coffee, even this seemed few and far between. CMHT shared with me that "they all knew the hours that were awarded to these kids didn't add up to the staff hours and in terms of the number of staff available". This was shared with me following Abbi's death.
17	Personal history incorrect. 1st paragraph – it was only Abbi and myself who moved into emergency temporary accommodation together. I did not return to my [I/S] ex partners home at any point. I did embark on a relationship with a gentleman who was to become my future husband (current) husband. There were times when I visited him alone. Abbi was 20 at this time and not 19
18	My understanding is: full time support from 1:1 not 12.5 hours as stated
21	Whilst Abbi was in the St Aubyn Centre (Longview and Larkwood but still EPUT) I was informed that I made up her diagnosis of autism. In addition it appeared that the staff listened in to my phone conversations with Abbie (as I had to be on speakerphone). The staff also prevented me from visiting Abbi and referred Abbi to safeguarding because of me but would not share with me what I was supposed to have done. Many more awful things happened at this place and Abbi never recovered from this admission. It destroyed her. My understanding is that her care co read Abbi's statement on what happened here and offered to support Abbi to go to the Police with it.
23	No one ever mentioned a referral to the Lorna Wing centre to me and although it is referred to on this page along with the Maudsley. Abbi was discharged into a general adult psychiatric mixed sex ward. It is worth noting that my understanding is that in April one consultant recommended a discharge to a unit specialising in treating autism and mental health difficulties yet 7 days later a placement is recommended for females with emotional difficulties but in the next paragraph is states that in September she was discharged to general adult services (Christopher Unit – Linden Centre)
23	We never heard from the Lorna Wing Centre and did not even know about the referral until the release of this document.
25	I was never informed about Abbi's diagnosis of Schizophrenia.
25	Inadequate support appears to have been given to Abbi to attend the Clozapine Clinic which was in Chelmsford and this is why she disengaged. Abbi struggled with public transport and found it confusing and overwhelming. She also became lost easily. (see 39)

25	<i>Community Care – all references to autism have stopped being referred to.</i>
34	<i>My understanding is that Pavillion Court only notified the Police that Abbi was missing due to her friend raising the alarm and not because they had realised Abbi was missing.</i>
39	<i>Abbi will not accept Clozapine as she struggles to travel on a bus as it confused and overwhelmed her. I had reported this to clinicians and was told nothing could be done. Pavillion Court had told me Abbi would need to get used to being unsupported and doing things such as travelling alone as they were not a permanent placement. Abbi was often reminded of this and is scared her.</i>
52	<i>Abbi didn't understand dates / months etc, or even time, and I supported her with a visual paper calendar and online calendar. She still found it difficult to understand and record dates. Even having a date written down would not mean that this would equate in Abbi's head. I set alarms on my phone for days / dates / times and tried to support Abbi to ensure that any appts were attended. It appears that Pavillion Court did not support her with this bearing in mind her LD and low IQ.</i>
56	<i>[context] I actually said she needed more support in the community in order to engage with life in a meaningful way and that inpatients admissions were not the answer.</i>

225. Dr **A** states in his report many important points in his opinion section regarding Abbi's autism and mental health care. I am of the view that this is important information not only for insight into the lack of Abbi's care, but also for those patients who had similar challenges to Abbi.

226. In response to the question, "Did Abbigail's previous lengthy detention impact on her presentation in the months preceding her death?" Dr **A** states:

"...10.3.1. Within the diagnostic formulation set out above, I have noted the areas in which, in my opinion, there is insufficient evidence to support some of the diagnoses that have been made...

10.3.3. I note the impact upon Abbigail Smith of the COVID-19 pandemic and lockdown periods and whilst, generally, those times negatively affected people's mental health, there are aspects of the progress notes that specifically identify that she struggled with a loss of structure and routine, that she found the 'rules' difficult to understand and that she further struggled with the changes to her supportive and 'safe' social networks; there is evidence of social isolation and I would again refer to the risks, in such circumstances, regarding rumination and low mood ...

10.3.4. I note that Abbigail Smith discontinued her prescribed CLOZAPINE and that she experienced an extremely rapid emergence of distressing symptoms; in a true psychotic illness, for which an individual is adequately treated, in my experience it would be usual for a gradual emergence of symptoms over a 4 – 8 week period.

*10.3.5. Thus, I query as to, given the broad receptor spread for CLOZAPINE (in that it works on a very wide range of neurotransmitters and receptors in the brain) whether Abbigail Smith's presentation in **October 2021** was the manifestation of anxiety and a re-emergence of partially treated trauma combined with the additional social stressors of the pandemic and her interpersonal relationships. In support of this hypothesis, I would point to the rapid improvement within her presentation upon prescription of QUETIAPINE which, whilst an antipsychotic, also has significant anxiolytic properties and would also fall within the broad NICE guidelines for treatment of PTSD.*

*10.3.6. Based upon my reading of the available records ...there is clear evidence of a deterioration, but subsequent stabilisation, within Abbigail Smith's presentation **subsequent to October 2021** and then the further precipitous deterioration that led to an increase in alcohol*

use and the presentations to A&E in **January 2022** and the subsequent admission to hospital subject to detention under s2 MHA. I would also note that, whilst she referenced **difficulties** [I/S] within her relationship with her ex-partner, the records do point to him previously providing **a high level of support**; this would have been **absent** post-discharge and – thus – would have **compounded** both her recorded issues related to returning to an environment associated with trauma but also her feelings of isolation and low mood; in my opinion, in the context of her **autism**, this would have been a **dynamic risk factor that was not properly explored or factored to discharge planning in February 2022...**” (emphasis added)

227. In response to the question, “Abbigail was diagnosed with autism spectrum disorder (ASD) in 2006. Please explain in general terms how autism affected her”, Dr **A** first explains in his report the relevant diagnostic criteria for autism that would have been applicable. Dr **A** goes on to state:

“... 10.4.5. In the case of Abbigail Smith, it should also be recognised as to the impact of gender upon presentation, with there being a clinical and research consensus that the existing diagnostic criteria are skewed towards a male phenotype and that females are underdiagnosed, more likely to be diagnosed later in life, to be misdiagnosed with conditions such as EUPD and to present at the point of crisis/burnout. It has also been suggested that females are better able to compensate for symptoms, despite having evidence core deficits associated with autism, and there is a body of research that confirms that females must exhibit more severe symptoms, impairment or cooccurring problems in order for a diagnostic referral and assessment to be undertaken. It is additionally recognised that females with ASD perform better on measures of non-verbal communication (which may mask other symptoms), and face more social, friendship and language demands than males with ASD and that females with ASD can exhibit patterns of restricted interests and repetitive behaviours as well as social and communicative problems that are deemed more socially acceptable as compared to the patterns seen in males with ASD

10.4.6. With regard to the presentation of Abbigail Smith in the context of her ASD, I would point to the diagnostic formulation as set out above and that there was an absence of any formulation process that took account of her ASD, cognitive deficits, history of institutionalisation and her clear history of multiple episodes of trauma. Understanding the phenotypic differences in the presentation of autism is critical and it is crucial to understand that aspects of the diagnostic criteria for ASD may present on other ways in females though not be elevated on standard measure scales; as a result, those who do not receive an appropriate diagnosis will subsequently not receive an appropriate intervention ...

10.4.7. Beyond the obvious concern associated with autistic females not receiving intervention associated with their autism symptomatology (and I note no reference to autism within the Paris progress notes and no acknowledgement that Abbigail Smith was autistic within the vast majority of the clinical records, admission information and discharge summary from the Linden Centre), there are a range of other mental health concerns that may dually go unaddressed

10.4.8. Autistic females are at greater risk of developing depression and are also at increased risk for suicidality (as noted above) and there is more recent research that confirms that, while those with ASD may be able to mask their symptoms the majority of the day and – thus – not reach the diagnostic threshold in standardised measures, doing so causes them significant distress and puts them at increased risks for such co-occurring mental health concerns; I specifically raise this in the context of the unassessed and – arguably – unappreciated impact of hospital admission upon Abbigail Smith, the significant sensory, emotional and cognitive demand that she experienced that is recorded in the notes, that she continued to voice specific suicidal ideation with planning throughout her admission (and this is in contrast to her presentation within the 2 year period covered by the progress notes and other records) and that there was no considered discharge planning to account for the likelihood of an autistic ‘burnout’ and the impact of this and the monotropism as set out above...”

228. In response to the question, 'Would Abbigail have benefitted from specialist support in relation to her ASD when receiving in-patient treatment for her psychiatric/psychological problems?', Dr A states in his report:

*"... 10.5.1. In consideration of the available records – and as a starting point – Abbigail Smith would have benefitted from a **fundamental acknowledgement** that she was autistic and this diagnosis should have been included on her records and considered within formulation, care planning, treatment and discharge planning.*

*10.5.2. As has been noted within a number of other unfortunately similar cases across the country, the failure to acknowledge that someone is autistic **leads to their presentation being attributed to alternative diagnoses** (often with pejorative consequences regarding intention of actions and treatability), the failure to appropriately assess risk and the further failure to provide care and treatment that 1) would be in line with existing best practice and 2) would be efficacious or, as a minimum, not harmful."* (emphasis added)

"10.5.3. Whilst post-dating Abbigail Smith's death, the NHS England publication 'Meeting the Needs of Autistic Adults in Mental Health Services sets out an evidence base that would mostly have been available at the time and confirms reasonable adjustments to services that would have been in-line with NICE guidelines and similar policy documentation as set out within Section...

10.5.4. Abbigail Smith would clearly have benefitted from her care and treatment being underpinned by consideration of the correct diagnoses, their manifestation and impact upon risk assessment.

10.5.5. I would also note that, had Abbigail Smith's autism been recognised and duly recorded, then she would, in-line with national policy, have been eligible for inclusion within a Dynamic Support Register (DSR) that flagged the increased risk of admission (and relevant reviews of her care and support) and a further Care and Treatment Review (CTR) regarding admission and discharge planning would also likely have been warranted; whilst the relevant policy documents were updated in 2023 (and are recommended to be included as statute within the Draft Mental Health Bill), the previous iteration, published in 2017, sets out the policy background:

10.5.5.1. 'CTRs were developed as part of NHS England's commitment to improving the care of people with learning disabilities, autism or both in England with the aim of reducing admissions and unnecessarily lengthy stays in hospitals and reducing health inequalities.

10.5.5.2. The aim of the CTR is to bring a person-centred and individualised approach to ensuring that the care and treatment and differing support needs of the person and their families are met, and that barriers to progress are challenged and overcome.

10.5.5.3. CTRs are being driven by the NHS but involvement of local authorities and education services in the CTR process and its outcomes are necessary for improving care and treatment for people with learning disabilities and their families

10.5.5.4. The 'spirit' in which CTRs are carried out is paramount and is rooted in principles of human rights, person-centeredness and co-production.

10.5.5.5. CTRs are a part of a wider model of service development and delivery laid out in 'Building the Right Support' (BRS) and the related service model for commissioners of health and social care services. Fundamental to this is the expectation that people with learning disabilities and autism or both who present mental health problems and / or behavioural challenges and who have been admitted to hospitals in the past or whose support to live in the community is vulnerable, are generally already well known to services. There should be a

proactive and responsive process of monitoring and review that can anticipate and meet the needs for extra and / or specialist support in a timely manner to prevent or proactively manage crises.

10.5.5.6. The implementation of CTRs across the patient care pathway aims to [with emphasis added by myself]:

✓ Empower and support people and their families to be listened to and to be equal partners in their own care and treatment pathway.

✓ **Prevent people being admitted unnecessarily into learning disability and mental health inpatient beds through identifying alternatives where appropriate.**

✓ **Promptly review the proposed care and treatment and discharge plans of people who have been urgently admitted to hospital.**

✓ **Ensure that any admission is supported by a clear rationale of planned assessment and treatment together with defined and measurable intended outcomes.**

✓ Review care and treatment and discharge plans of people who have been inpatients for a defined period of time (or sooner by request where there is dissatisfaction with progress).

✓ **Ensure that all parties work together with the person and their family to support discharge into the community (or if the only option, to a less restrictive setting) at the earliest opportunity’.**

✓ Ensure the involvement of the local authority including, where appropriate, children’s social care, adult’s social care, the Special Educational Needs (SEN) team, or school or college so that all relevant issues can be fully addressed and solutions explored for the discharge of people into community based settings, or back home to their families.

✓ Support a constructive and person-centred process of challenge to current and future intended care and treatment plans where necessary.

✓ Identify barriers to progress and make clear and constructive recommendations for how these could be overcome.

✓ Result in an agreed action plan at the end of the CTR that has clear actions, each of which is allocated to a named individual together with a specific timescale.

✓ **Improve health outcomes through early access to the most appropriate services and the provision of integrated and holistic care.”**

“10.5.6. I would contend that, whilst the policy further sets out that a ‘CTR should not be used to delay or obstruct the process where a clinician has determined that there is an urgent need for admission to an acute mental health facility when the individual’s mental health is posing a significant risk to themselves or others or the person is being admitted as part of a pre-determined crisis management plan and where there are clear aims and projected plans and timescales for discharge’, **there is no evidence that any of the clinicians involved in Abbigail Smith’s care were aware of this policy process (or that of the DSR) and – thus – a key opportunity to review her care and treatment in the context of her autism was missed; it is further notable that neither the DSR or CTR processes are referenced within the PSII Report** and – thus – I would express systemic concerns as to whether, and how, the Trust is adhering to national policy and how this is being communicated to staff...”

(Emphasis added)

229. In response to the question 'Was Galleywood Ward at the Linden Centre able to offer specialist support for patients with ASD? If not, were there potential benefits for Abbigail's health associated with a discharge into the community, with suitable support? If so, what would constitute suitable support?', Dr A's report states:

"... 10.6.1. Within the statutory Mental Health Act Code of Practice, Section 20.20 onwards sets out:

*10.6.1.1. 'Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism, who may be very distressed by even minor changes in routine and is likely to find detention in hospital anxiety provoking. Sensitive, person-centred support in a familiar setting will usually be more helpful. Wherever possible, less restrictive alternative ways of providing the treatment or supporting a person should be found. The specialist expertise and skills of staff should be regularly audited, particularly the ability to recognise social and health needs, and specialist communication skills ... **a person with autism may have additional sensory and motor difficulties, which make them behave in an unusual manner which might be interpreted as a mental illness but are, in fact, a coping mechanism**'*

10.6.1.2. 'These include sensitivity to light, sound, touch and balance and may result in a range of regulatory behaviours, including rocking, self-injury and avoidance, such as running away'." (emphasis added)

"... 10.6.2. Within 'It's Not Rocket Science', commissioned by the National Quality Improvement Taskforce and published by the National Development Team for Inclusion (NDTi), dated 2020, the relevance of sensory differences for autistic people are further noted, setting out the need to address these within in-patient environments (and beyond); the report highlights the legal duty under the Equality Act 2010 to make reasonable adjustments to services and that 'Hospitals are difficult places for lots of people, and can be particularly harmful for autistic people, with additional sensory sensitivity and misunderstanding of autistic communication and culture. It's unlikely that autistic people will thrive in hospital'"

10.6.3. Whilst the report will not be reiterated at length, the specific recommendations are worthy of note, particularly given their relevance to this case:

10.6.3.1. 'Create a predictable environment. Let people know what to expect, who to expect and when. Offer accurate and timely information to create more certainty and support a feeling of safety.

10.6.3.2. Involve autistic people with relevant expertise in reviewing the sensory environment, in a meaningful way. Every location is different and will have different things that need to be prioritised. Autistic people have different sensory perceptions, so it's critical to involve people. Listen and take action.

10.6.3.3. Continue to review. It can be beneficial to bring in external expertise, but it's also important to involve people using the space. Ask them what's working and what needs to change.

10.6.3.4. Ensure all staff have training from autistic experts and allies that understand autism and sensory needs. All staff includes the MDT, healthcare staff, the ward team, facilities staff educators, cooks, cleaners, and agency staff. Each of these roles impacts on an autistic person's experience.

10.6.3.5. Assess everyone's sensory need on admission and consider how sensory need will be accommodated and supported in care plans. Support people to reduce problematic sensory inputs and manage these to support restraint reduction. As part of care planning, support people to do the things that help them to self-regulate, including repeated movement ("stimming"),

access to hobbies and favourite possessions, quiet spaces, outdoor space, and access items such as noise cancelling headphones, caps, blankets, etc

10.6.3.6. Personalise risk management and decision making. Support people to have choice and control. Make decisions in relation to individuals, involving the person (and their family, as appropriate) wherever possible. Avoid blanket bans (decisions or bans that affect everyone, rather than being decided on an individual basis)'.

10.6.3.7. 'Swap alarms for 'silent' alarms. This will significantly reduce noise and escalation on the ward and reduce the frequency of distress caused by alarms for those with auditory sensitivity. Staff need to be alerted – silent alarms will support this to happen without causing distress to other people.

10.6.3.8. Reduce noise and echo. Ensure there is quiet space and outdoor space that people can access at any time. Soft furnishings, gently closing doors, carpet, sound absorbing panels and acoustic vinyl can all help. Consider background noise too (including roads, heating and cooling systems, extractor fans, voices, keys, TVs/radio, etc). Ensure there is an actually quiet space and outdoor spaces people can access at any time.

10.6.3.9. Consider the impact of lighting and support user control. Hypersensitivity to lighting can be painful. High quality bulbs and component parts can reduce potential flicker and noise (which can be more likely if lights are dimmable). Ensure that lights can be turned off easily, that low level lighting is available, and that lights are warm yellow and diffused (shaded)

10.6.3.10. Consider the impact of smells. This includes smells from people, food, cleaning products, and laundry products. Neutralise smells wherever possible (closing doors, using unscented products, supporting people to 'mask' smells with preferred scents, or to use preferred products).

10.6.3.11. Consider the impact of touch and texture. Hypo and hyper sensitivities might mean that people may be more, or less, sensitive to physical contact. This needs consideration in relation to potential physical restraint (best avoided), food, shower/bath/personal care and textures of materials including bedding, furniture, clothes and towels'."

"10.6.4. Although marginally post-dating the death of Abbigail Smith, from hospital, it is noteworthy to further consider the NHS England recommendations that flowed from the NDTi document and were set out within the publication 'Sensory Friendly Resource Pack' (NHSE, 2022), confirming that **'environments that are not 'autism friendly' can impede the effectiveness, or hamper the delivery of, therapeutic intervention; exacerbate poor mental health [and] lead to the use of restrictive practices such as restraint, seclusion or segregation'**.

10.6.5. In the case of Abbigail Smith – and at a fundamental level – any ward can only put in place reasonable adjustments if a person's diagnosis is correctly recorded and recognised. **I have not been provided with information related to the Trust's autism strategy or application of initiatives such as the Green Light Toolkit or adherence to Transforming Care; I would also note that there is reference to the suitability of in-patient wards within, as examples, the MHA Code of Practice (as above) and the Mental Health Act Monitoring Reports prepared by the Care Quality Commission.**" (emphasis added)

"10.6.6. I note (and have included the example within the nursing entry on the day of discharge) that it is recorded that Abbigail Smith was autistic but that this is **not included in any documentation** related to observations, risk or her care plan; I would also note that the erroneous information from the Mental Health Act assessment that related to another patient continued to be recorded within Abbigail Smith's records." (emphasis added)

“10.6.7. With further regard to Abbigail Smith’s **care plans**, I note these to be **generic** (and – indeed – there is evidence that the care plans are ‘cut and pasted’), **non-specific** (for example, the care plan related to self-harm and suicide focuses on sexual safety and the behaviour of other patients), are **incomplete** (again, as an example, they do not stratify the identified risk or include the dynamic risk factors and events during the admission or Abbigail Smith’s self-disclosures) and do **not include the views** of Abbigail Smith; I further note the **conceptualisation of risk to be wholly based upon an EUPD diagnosis** and – again – there is **no evidence of any consideration as to Abbigail Smith’s autism or the impact upon risk management**.

10.6.8. I would further draw attention to the **treatment considerations that were outlined (again with a focus on EUPD)** and that the suggestion that Abbigail Smith would benefit from ‘psychological/psychotherapeutic interventions in the community’ is again **predicated on an incorrect diagnostic formulation** and does not take account of the research evidence as to the efficacy (or, perhaps more accurately, the lack of efficacy) for interventions such as Dialectical Behavioural Therapy (DBT) for autistic people.

10.6.9. I do not criticise the support that was afforded to Abbigail Smith by [redacted] there is evidence that she understood the presentation of Abbigail Smith, expressed clearly her views regarding risk assessment and that she was not involved in the decision to discharge Abbigail Smith from Galleywood Ward. I note the concerns raised by [redacted] as to the on-going risk of completed suicide by ligature and that the **recommended support structures were not put in place prior to Abbigail Smith leaving the ward**; I would also note the consideration given, at the point of discharge, to **further detention under MHA**.

10.6.10. I would question the degree to which the community team viewed Abbigail Smith’s presentation in the context of her cognitive deficits and autism. However, I would suggest that this relates to a **whole-systems approach to the provision of healthcare within the Trust for autistic people** (and I make that comment based upon this case and the broader comments and responses within the PSII)...” (emphasis added)

230. In response to the question ‘What would have been the potential benefits to Abbigail of receiving such specialist support?’, Dr [redacted]’s report further states:

“...10.7.2. Taking into consideration that the majority of autistic people do not have a learning disability – and that autistic people are over-represented within planned and crisis mental health services – it therefore follows that the majority of autistic people (outside of forensic services) will be admitted to acute mental health services; for information, such admissions, compared to patients that are not autistic, tend to be longer in duration and there is clear evidence that they are associated with the application of greater levels of restrictive interventions.

10.7.3. The provision of ‘specialist’ support is variable across the country and there is no defined and mandated minimum standard for such services, their configuration and funding; clearly, there is a legislative framework within the Equality Act as to reasonable adjustments and a diagnosis of ASD should not be a barrier to parity of access to mental health services and settings. Whilst there likely would have been benefit to Abbigail Smith’s overall care having been informed by autism-specific considerations, I revert back to the fundamental point that, for such interventions to even be considered, there would need to have been recognition that she was autistic; without such recognition and documentation, whether or not the Trust had access to specialist services, scaffolding or consultancy becomes wholly moot.

10.7.4. Were Abbigail Smith’s autism diagnosis to have been recognised and integrated into her care provision then there would likely have been a clearer formulation of need that took account of her presentation, coping strategies, processing of information, suicidality, history of trauma, coping strategies and a more individualised assessment of risk; whilst, arguably,

hindsight has a clearer focus, the records confirm that Abbigail Smith's presentation was not in keeping with the previous 2 years, that she was repeatedly expressing significant suicidal intent by ligature and that discharge returned her to the same situation associated with significant trauma in the immediate pre-admission period and without any alteration to her level of support or coping strategies (and this would likely have been highlighted within a CTR review) ..."

231. In response to the question 'Are there residential psychiatric units in the UK which specialise in providing support for patients with ASD? If so, would Abbigail have benefitted from an admission?', Dr [A]'s report states:

*"...10.8.1. As stated above, the majority of autistic in-patients, aside from those within forensic settings, are admitted to acute in-patient settings. It is further recognised (as above) that **prolonged admission is rarely helpful and often leads to institutionalisation and repeated trauma; this is true in the case of Abbigail Smith**" (emphasis added).*

"10.8.2. As set out within the quoted CTR guidance, the purpose of admission should be clear and time-limited and – whilst I note references within admission documentation and MHA paperwork that Abbigail Smith would benefit from functional assessment and occupational therapy assessments prior to discharge – I cannot identify that these occurred or that there was any review of the care package.

10.8.3. In terms of hospital settings or residential care settings, there is no specific registration category for such services within the Care Quality Commission; accordingly, there is no benchmark by which a service would be deemed to be 'specialist'. There are a small number of NHS services for care treatment of autistic people (as a primary diagnosis). However, in terms of the admission between January – February 2022, I do not believe that such a prolonged admission would have been helpful. I do, however, question the formulation and risk management that was employed within the entirety of the period subsequent to Abbigail Smith's discharge from Cygnet Hospital Beckton and again would express concern as to the apparent absence of any discharge formulation from that service that took account of her autism (and that locality services did not question this)..."

232. With regards to further questions on to what extent autism was factored into in-patient / out-patient treatment and on reasonable adjustments, Dr [A] states:

"...10.9.4.1. I refer the reader to the extensive comments that are set out in the responses above as to reasonable adjustments that may have helped Abbigail Smith; these relate to acknowledging the diagnosis, understanding of her autism in the context of suicidality and emotional dysregulation, the interplay between her autism, her cognitive profile and her history of trauma, the manifestation of her autism in terms of processing and utilisation of coping strategies and reasonable adjustments to the provision of information (both in terms of cognitive understanding and her communication)

10.9.4.2. I would also note that Lisa Wolff provided Galleywood Ward with a range of information regarding her daughter's diagnosis and care needs and yet there is no evidence that this was acted upon, that records were requested, that care plans were amended or that Abbigail Smith's care was in any way altered or personalised in the period (of over a week) prior to her discharge..."

233. In response to the question 'Were the activities to which she was given access appropriate and of potential benefit to her?', Dr [A]'s response includes the following:

*"...10.10.2. Whilst Abbigail Smith was able to access activities both on the ward and in the community, there is **no evidence** (particularly regarding the former) that these took account of*

her **autism, cognitive profile, interests, sensory preferencing or proprioceptive and co-ordination abilities.**

10.10.3. I would additionally again note that, whilst admission served to temporarily remove Abbigail Smith from the trigger situation (of her accommodation and the ending of her relationship), there **was no consideration as to how this would be addressed whilst an in-patient** or the degree to which her autism and history of trauma would not be **re-triggered** upon return to Pavilion Court..." (emphasis added).

234. Dr [A] also states:

"... 10.11.5.1. There is no evidence that services took account of Abbigail Smith's autism when devising any aspect of her care and treatment; the only clinician that appears to have taken into consideration specific aspects of her presentation was Dr [S] and her actions ... were based upon a general (but wholly appropriate) low stimulus approach to her presentation in Accident and Emergency"

235. In response to the question 'To the extent that you identify any failure(s) to address the needs arising from Abbigail's autism, what were the risks associated with those failures and what was their impact (if any)?', Dr [A] states:

"...10.12.1. I again refer the reader to the extensive comments above that set out the **fundamental failure** to identify Abbigail Smith's autism diagnosis and the **subsequent impact** upon all aspects of her care, treatment, risk assessment and discharge planning..." (emphasis added)

236. I believe it is important for the Inquiry to see what difference it makes when Abbi was approached in a way which 'spoke her language'. Accordingly, with regards to Dr [S] treatment of Abbi, I have reproduced what Dr [A]'s report quotes from Dr [S] statement dated 10 March 2023:

"...18.14.1 When Abigail arrived in the Emergency Department she was distressed, agitated and was in **handcuffs and leg restraints**. Within the room there were multiple personnel, mostly male, including paramedics, police, hospital security officers, nursing and health care support workers. The room was noisy and crowded.

8.14.2. In accordance with NICE and RCEM guidance, environmental **de-escalation** techniques were immediately implemented and the room was cleared of all personnel, except for two security officers, in order to create a calmer, quieter and less crowded environment.

8.14.3. To the best of my recollection, shortly after the implementation of environmental de-escalation strategies, Abigail became **less distressed** and was no longer attempting to harm herself.

8.14.4. At this time I entered her room and sat on the mattress on the floor at the same level as Abigail. Using the domains of de-escalation in accordance with RCEM guidelines I was able to build a rapport with Abigail and ascertain that she had a history of self-harm, suicidal ideation and had recently spent time as an inpatient in a psychiatric hospital. She divulged to me that her mood had deteriorated since the breakdown of a difficult relationship and that she felt suicidal. I carried out a mental capacity assessment and this demonstrated that Abigail did have capacity ... carried out a physical examination of her head and neck and found no significant injuries secondary to her attempts at self-harm.

8.14.5. While assessing Abigail, she attempted to put her hands to her throat again. As per the NICE guidelines on self-harm I did not immediately attempt to prevent this. As per RCEM guidelines I verbally engaged with Abigail and tried to reason with her about her actions, exploring her wants and needs. Abigail responded positively, removed her hands and became

calmer. Following my assessment I made a referral to the psychiatric liaison team for further evaluation and assessment.

8.14.6. Abigail made one further attempt to harm herself with the cord from her hooded jumper. She was immediately restrained by the security officers in her room and the cord was removed (as the risk of harm posed to herself by ligaturing with this cord was significant). Following this restrictive intervention, Abigail once again became calmer and made no further attempts to self-harm or leave the Emergency Department...”

My comments regarding Dr A's Report

237. With regards to Dr A's report, I anticipate that the Inquiry will want to see the report in full. Accordingly, it important to me that I include in my statement some comments I have with regards to some entries in his report.

238. At 5.37.12 the report discusses a ward review dated 9 February 2022 and notes the following:

“...Risk to others – There is history of being violent and aggressive towards others. There is a propensity for impulsive angry outbursts and low frustration tolerance. Currently there appears to be no outstanding charges against her....”

I would like the Inquiry to note that I have never witnessed violence from Abbi towards other people, all violence has always been aimed at herself. I do not know of anyone who has ever said that Abbi has been violent towards them.

239. At page 30 of the Dr A's report, under the “summary of progress notes...” section, next to 26.05.21 - it mentions the transition from Pavilion Court to independent living and quotes:

“... Abigail says that she is able to do most things independently such as paying bills, cooking, cleaning etc...”

With regards to the transition, I would like the Inquiry to note that this entry demonstrates how little those involved in Abbi's care truly understood her. I had to set up all of her direct debits and she regularly called me with payment queries or if she received a letter she didn't understand. Abbi was incapable of doing anything on her own with regards to day-to-day living. Greg sorted out all of her computer queries and I sorted out all of her regular day-to-day queries. I even tried to devise a calendar with her so that she understood what was happening on which day. We spoke several times a day, every day (whilst out of hospital) but she never told anyone about the support that the family gave to her.

240. At page 35 of Dr A's report, under “summary of progress notes...” section, with regards to 01.02.22, it quotes:

“...Abby says that she feels as though ‘people aren't bothered with her’ I asked who she meant by this and she said her Mum and Sister. She said her Mum hadn't answered her call since being an inpatient and had not received any messages from her Mum or sister which Abby felt upset about...”

The actual position was that Abbi disengaged from her sister and myself, she stopped answering calls and texts (I still have them on my phone-unanswered). This is the time she also allegedly stopped me from enquiring after her by calling the unit for an update.

241. At page 35 and 36 of the report, Dr A is discussing a summary of the progress notes with regards to 03.02.22 - it mentions that Abbi was nursed on level 4, she had to be restrained in a

supine position, and had to be given oral intramuscular injection of promethazine. On 04.02.22, it is stated that Abbi was then nursed on level 3 observations and discusses three ligature attempts.

I am baffled as to how on 3 February it is noted that she was nursed on level 4 observations, had to be restrained in the supine position and forcibly administered medication, yet the very next day it reads she is on level 3 observations despite the fact that she ligatured 3 times that day.

242. At page 36 of Dr [A]'s report, under "summary of progress notes..." section, with regards to 05.02.22, it quotes:

"...Mother is of the view that A.S will benefit from more support for her in the community through her local CMHT, to have activities to structure her day and to have psychological/psychotherapeutic interventions in the community..."

My comments on the above are that I did not say Abbi requires more support from the CMHT - I said she requires more support to engage with life. Abbi was not supported to live an independent life, she was left alone to take care of herself in the best way that she could, with me offering as much support as I could. Some mental health support would have been fine but it needed to be delivered in conjunction with other agency support in order to deliver holistic care planning.

243. At page 38 of the Dr [A]'s report, under "summary of progress notes..." section, it states with regards to 09.02.22:

"... It is noted that Abby had said to staff the day prior that she was going to end her life upon discharge and asked the staff not to tell Dr [Q]. Dr [Q] was aware and we discussed this in the review. Dr [Q] is planning to discharge Abby on Monday 14th of February..."

With regards to the above, I am struggling to understand how Abbi can have informed staff that she planned to take her own life upon discharge and yet it is clearly documented that this very same day she was informed that she would be discharged five days later.

244. At page 39 of Dr [A]'s report, under the "summary of progress notes..." section, next to 14.02.22 events are described which do not relate to Abbi and actually caused Abbi great distress – which will be evident to the Inquiry from one of Abbi's self-recorded videos. The entry states:

"... It is also reported she was acting aggressively towards her family, became violent, was growling, spitting, shouting , and swinging from the ceiling lights, and that she had defecated in the kitchen..."

With regards to this, these notes do not relate to Abbi - the PSII report states, next to the date 24th January:

*"...In addition, the referral documentation included details that Abbigail had presented with aggressive behaviour and she had been violent towards her family; where she had growled, spat, shouted and had swung from ceiling lights and defecated in the kitchen. Upon review of the clinical records as part of this investigation, this information was included within the general hospital's records subsequently scanned into EPUT's clinical records system, **however these details were related to another patient...**" (emphasis added)*

245. I request the following from the Chair / Inquiry:

- a. I would like Andrew Geldard to be called as CEO of EPUT during my daughter's time in CAMHS inpatient unit (St Aubyn Centre). I wrote a complaint at the time and he simply referred me back to one of the clinicians I was complaining about. It is my opinion that my daughter's time at the

- St Aubyn Centre caused us both PTSD and she certainly did not recover. This inpatient admission paved the way for her decline. They completely refuted her diagnosis of autism and accused me of harming her in some way by virtue of making me the subject of a safeguarding enquiry (I still do not know why) and refused to allow me to speak to my daughter without recording our phone calls.
- b. I also feel it pertinent that the **ward managers of both Larkwood and Longview** at the time be called. Horrific and horrendous things happened to my daughter when under the "care" of this establishment. **Psychologist G** was a psychologist there, he laughed in my face when I highlighted my daughter had autism and said I couldn't prove it. He refused to look at any paperwork I took in to corroborate her diagnosis. He once invited me to a meeting and objected to the fact that I wanted to write down his answers to my questions and both he and Dr **[I/S]** who was also in the meeting, stood up and simply walked out on me. They made me feel like I couldn't parent my own daughter, or was actually damaging her in some way. I would also like **Psychologist G** and Dr **[I/S]** called to explain their actions. I tried to report the Saint Aubyn Centre to CQC and if I had been listened to with my concerns for safeguarding on the ward, perhaps any subsequent deaths could have been avoided.
- c. With regards to her last EPUT admission I would like:
- Dr **Q** called,
 - Dr **B** called,
 - Dr **P** (he is Cygnet, but my understanding is that EPUT have responsibility as **they placed** my daughter there),
 - Dr **C** called and
 - **O** called.
 - Someone in authority to comment on whether staff of appropriate seniority were dealing with Abbi's complexities and risk– to be called
- d. I would strongly suggest that the Inquiry needs to give serious thought as to appropriate sanctions and whether these are to be levied at individuals or EPUT themselves. My daughter wrote a note explaining that an EPUT member of staff had physically restrained her in a chair, whilst another had force fed her? Are these to be ignored or investigated? The Inquiry will only carry credence and be considered robust and thorough if it leaves no stone unturned – if the Inquiry rush this process then it would lead me to consider that the majority of the stones will be unturned!
- e. I have recently finished my daughter's Inquest where the Coroner found Neglect. How are the Inquiry team planning to address this? Will they dig further into my daughter's experiences by going back further to her time in the St Aubyn Centre to uncover the quite frankly horrific, damaging experiences we were subject to? Will they inspect the Coroner's findings, will they take these into account, will they call the clinicians who the Coroner levied blame at? From my understanding, the Coroner will be making a Prevention of Future Death report.
- f. This Inquiry must examine closely the individual components of Abbi's treatment which culminated in her death. The Inquiry must be able to eventually see the bigger picture of failure that is occurring and the systemic level of apathy towards the lives of the most vulnerable that EPUT is supposed to be caring for and protecting. An example of Abbi's vulnerability is portrayed in Dr **C**'s statement dated 23.01.2023 which states:

"...15.7 Ms Smith then disclosed to staff that she had been having contact with a male teaching assistant from her former school who had contacted her via Facebook. It appeared that Ms Smith had been responding to his messages using her phone whilst on leave. Ms Smith reported that she had agreed to meet him whilst on leave with staff as her other friends had been unable to go out with her on her birthday. Staff reported that she had indicated that the man offered her drugs and offered to support her in the community. He had made arrangements to visit Ms Smith on the ward but this was

cancelled at Ms. Smith's request as she indicated that he had been calling her during periods of leave and sending her multiple messages. She indicated that she wanted the messages to stop and a SETSAF was raised to safeguard Ms Smith due to her vulnerability. It later transpired that Ms Smith continued to make contact with the man. There was a previous incident on the ward involving a male patient who had been sending letters of marriage proposals to Ms Smith, which she reported to staff eventually resulting in the transfer of the male patient away from Christopher Unit. There were on-going concerns about Ms Smith's ability to safeguard herself in the community when shown attention by males..."

246. I remember both Abbi and I discussing the need for her to have an advocate, as she struggled to articulate her feelings in meetings / assessments. As a child, when in The St Aubyn Centre, she had access to an advocate that she knew well. When she became an adult she no longer had access to one, unless she referred herself every time she needed one and Abbi would never have been able to do such a thing, i.e. to refer herself. I was working full time, and Abbi struggled to get in touch with me sometimes due to not being allowed mobile phones on the wards. As a result, she would often go into these meetings without representation or advocacy. This is not acceptable, and if this still exists it needs to be changed so that anyone who is neuro divergent automatically qualifies for an independent advocate who remains assigned to them for the length of their inpatient stay. I encourage the Chair to make such a recommendation.

247. I have also disagreed with many of the decisions to section Abbi under the Mental Health Act. I have always been of the firm belief that Abbi needed targeted and appropriate support to allow her to engage with life and to enjoy it in a safe and sustained manner. Many times, I have been phoned by different hospitals and asked for my views on sectioning Abbi, and I have always replied that I am against it, and the reply has generally been that in order to keep her safe she needs to stay. I felt strong armed into agreeing.

248. In addition I am sad to say that I have little idea as to what Mental Health Act assessments may have been undertaken during many of Abbi's inpatient stays. In any event, to the best of my knowledge I was not present at any – this was not by choice. However, I do remember losing count of the number of times staff had nonchalantly told me that they had done CPR on her.

My comments regarding the Inquest

249. In September / October 2025, there was a coroner's inquest into Abbi's death under Article 2, for which I had legal representation. Prior to this, the Inquest had been postponed which was difficult for me. I had arranged to go on holiday after the previously listed dates to recuperate from the emotional toll, but the Inquest was moved to the autumn and I had to prepare myself again.

250. The Inquest was more draining than I realised it would be. I went into the inquest with no expectations other than wanting a really thorough and robust examination of the timeline and circumstances around her death, and that is most certainly what I got. I was relieved that the Coroner was so thorough; she left no stone unturned. I tried not to have any preconceived ideas as to what conclusion the Coroner would hand down. I hadn't expected the conclusion to bring me peace though, and for the most part it has. I think some anger is beginning to creep in knowing that I was right and that no one wanted to listen or help whilst Abbi was alive

251. The Inquest hearing on 24 October 2025 has been professionally transcribed by a third party – this is not an official court transcription. On this day, the **Coroner's conclusion** was heard. I am of the view that this document is essential for the Inquiry to review. In any event I have extracted the below information from the transcript which, I consider, is essential to be brought out in public. Please note that in the professional transcript Dr [C]'s and Dr [Q]'s names have been

incorrectly spelt and therefore I have corrected the same in the below extracts by putting the correct names in square brackets. Mr [R] as referenced below, was Counsel for the family Mr [I/S] was Counsel for Cygnet Healthcare. Ms [I/S] was solicitor for MSE.

"...Abbi was reported missing on the morning of 16th February 2022 by staff at Metropolitan Thames Valley. I am satisfied, in the circumstances relating to Abbi, that this report should have been made sooner. Abbi had been discharged back home on the afternoon of 14th February with no obvious plan or update given to the care team at Pavilion Court. They made some of their own enquiries with the care coordinator and were told to take charge of Abbi's medication but there was very little by way of care plan or understanding otherwise. Abbi was seen in the morning for her medication and later for a chat with one of the Pavilion Court staff. Abbi then did not turn up for her evening medications at 19.30 hours and this was escalated to the on call person, [I/S] who did not have much experience of carrying out the on call in this role. There should have been some consideration as to why Abbi had not come for her medication. She had just been discharged some 24 hours earlier from section of the Mental Health Act with no care plan for the supported living and they knew she had had three recent admissions to hospital. They had called two of the ambulances in January that took Abbi to hospital due to her prolific self-harming and distress and they knew Abbi had been discharged from her section a day before.

A check in her room by [I/S] with [I/S] on the phone only established she was not present. I am told that is what the check was for. There was no call to Abbi's mother, who had been involved in her care. I accept the evidence of Lisa Wolff, as with many young people, Abbi was never without her phone and she said it was usually glued to her and that this should have caused urgent, urgent concerns for Abbi and that Lisa had an app on her phone, Find a Friend, for Abbi's phone and had been successful in locating Abbi in the past. I accept this evidence and that this would have shown Abbi's phone in her room. This would have not taken long and this would and should have caused immediate alarm bells....

This was a missed opportunity to locate Abbi...

Abbi, during her time that she was being cared for by a number of different services, did not have her autism and her learning disability at the forefront of her treatment. I accept the evidence of Dr [A] that this had a profound and significant effect on Abbi. We have heard, both from Dr [A] and other psychiatrists with significant experience, that there can be overlap between autism and other mental health conditions, that some people will have autism and that some autistic people may have an increased risk of developing a mental health disorder and we have heard a number of reasons why that may happen and some people may have a mental health disorder and autism and learning disability. I am not satisfied that this was explored either as a child, when Abbi was in [inaudible] services or as an adult.

Nothing in the records holds Abbi as having any adjustments for her autism or her learning disability for how this affected Abbigail. Autism is not a one size fits all diagnosis. Whilst it has common features and expressions for many people, how people experience their autism can be very individual and what people can learn to tolerate within their symptoms and their challenges with their diagnosis can be very different. There was no individual assessment to understand how Abbi's autism was experienced by her. There was no care plan or positive support plan or hospital communication plan for staff to understand how to communicate with Abbi. There was nothing about Abbi's triggers or how to communicate with Abbi if she was experiencing challenges or crisis. This was fundamental to assist Abbi.

The majority of staff involved with Abbi over the years did not have training in autism. One of the few organisations that I heard that did have some training and did mention in their records about how to deal with an autistic person and how they should not be overmedicated was Metropolitan Thames Valley, the Pavilion Court staff. This may well be why Abbi had some better relationships with staff at Pavilion Court and sought them out at times to have discussions and coffee over the several years Abbi was there.

Some key people who were involved with Abbi and particularly her care coordinators, I have heard about [I/S], who was originally Abbi's care coordinator on discharge from Cygnet, but also O. Whilst she did have a good relationship with them, they were not trained in autism. Ms O has stated now that she has completed the Oliver McGowan training on autism but shared no specific insight, even after that training, to how Abbi's autism may have specifically affected her. She said, and I accept, that she tried to treat Abbi as an individual but key to this was understanding who Abbi was and Abbi's autism and learning disability were part of who she was, a fundamental part of who she was and how she experienced all of her world.

There is, as Dr A says, a complete absence in references in the records, care plans, assessments and diagnosis as to how Abbi's autism affected her. I have heard from Dr P, a specialist personality disorder psychiatrist, and from the psychologist at Cygnet that they were aware that Abbi had autism but their evidence is confusing and disputed from their written evidence to their oral evidence. The psychologist stated in evidence she did agree Abbi had autism but there is a complete absence in the psychological records of this. I do not accept the evidence of Cygnet that they did anything to make any adjustments for Abbi in her care and treatment whilst she was there. The psychologist said that Abbi was offered adherence dialectic behavioural therapy and that this was not the adjusted form. She could not recall, at the time, whether there was an adjusted form available within the service at that time...

Looking at Abbi's learning disability, it is fundamental and also part of Abbi that she had a learning disability. Her Wechsler score being 72 would have put her just on the score sheets within the mild range but there was further evidence about her cognition and cognitive understanding that would have put Abbi in a more moderate range for comprehension and cognition and I am satisfied that whilst Abbi gave perhaps an impression that she can understand, we have the evidence that she frequently found this difficult, her mother having to explain things to her [inaudible] at meetings she may well not understand...

I am not satisfied that Abbi's diagnoses were all correct...

I am satisfied there was an absence of care plans and risk assessments related to Abbi with her autism. There were no care education and treatment reviews. Abbi was entitled to those throughout her admission at Cygnet and during her community care, one of the purposes being they are to support people with autism and learning difficulties and part of the purpose is to avoid hospital admission. I am satisfied there was no training for those who cared for Abbi and the responsibility to try to report and effect these was not just the responsibility of one person or organisation and that reports should have been made to the integrated commissioning board for Abbi when these things were not being done and I am satisfied that this did have a significant effect on the progression of Abbi and her care and treatment. Getting the right professionals around the table for Abbi in this situation would have highlighted some of the absences of care plans and risk assessments for Abbi as an autistic person with learning difficulties.

Abbi was under the care of the community team back in Essex. Abbi, we have heard evidence, had complexity in her presentation and I am also satisfied that with her different diagnoses, she

left Cygnet with a diagnosis of simple schizophrenia. Dr [P] did not make detailed references or recording in the records about how and why he achieved this diagnosis. He said it was the first time he had discharged a patient like Abbi with such a diagnosis and therefore the absence of this rationale is somewhat surprising. It is further surprising that this was not recorded into the psychology records and there was not more professional curiosity about that from the psychologist. I am satisfied, during the time that Abbi was with Cygnet, that her reports and records were being shared with EPUT and so the psychology records not reflecting the diagnosis with which she left and her issues as an individual person experiencing autism I find would have made a significant difference, which I turn to later.

I am not satisfied that someone with Abbi's complexity should have been assigned to the community team core trainees. Technically, Abbi had a responsible clinician, [Dr C], and we have heard and will turn to what [Dr C] said about her workload. During this time, one of those described as a core trainee was on what was called a WAST program and I am satisfied that was correct. It was reflected in the records and had Abbi under her care at the time the diagnosis that had been removed by Cygnet of emotionally unstable personality disorder was reapplied. Again, this was a significant matter for Abbi and there is no recording in the records as to how or why this happened. It is possible that the core trainee reviewed documents and saw this on the psychology records and applied it. [Dr C] says that she cannot recall it and I appreciate, after the passage of time with nothing in the records, I would not necessarily expect her to remember. It is possible, she said, that she had a discussion about this. She would have hoped that she did but there is a complete absence of any rationale for this and it is specifically hard to understand given the amount of time Abbi spent at the Tier 4 specialist service who removed this diagnosis to reapply it, specifically to reapply it with no recourse to the specialist Tier 4 unit where Abbi was sent by EPUT precisely for care and treatment because of their expertise. I am not satisfied this was reasonable or appropriate under the circumstances to have no liaison about this. The only entry in the medical records is a clinic letter to the GP with the diagnosis reapplied...

I am satisfied, and prefer the evidence of Dr [A], this had a significant impact on Abbi and made her condition significantly worse. Abbi was not listened to or understood in the context of her neurodiversity and neither was her mother, who was both trying to advocate on Abbi's behalf but also trying to support her to live a more independent life as an adult woman who had spent so long in mental health hospital not being able to make even small independent decisions for herself. I am satisfied Covid restrictions had some impact but, even so, staff at Pavilion Court would have been assisted by this. There were no care and treatment reviews either before, during or after Covid times for Abbi. I am satisfied she would have benefited from these but they were not a statutory requirement but they were simply given no consideration whatsoever.

I am satisfied there was a lack of knowledge and training within all services and I am not satisfied that that has been remedied today. Whilst I heard [O] has undergone training, I have heard from [Dr C], a consultant psychiatrist, that she does not have this training.

Abbigail had some challenges during 2021. Some of them were small and shortlived and Abbi coped with them. She did have a difficult relationship [I/S] but, again, Abbi coped with this. Abbi became non-compliant with her medication and I am satisfied that this was noted in the first instance, it appears, by her ex-boyfriend at the end of September. This was made to Pavilion Court staff and I am satisfied they did escalate this to the mental health trust...

*This medication had had a benefit, as I said, in a background history where olanzapine and quetiapine had not been effective. Evidence was this was not escalated urgently enough to the responsible clinician. Pavilion Court escalated to the mental health trust again on 1st October but this was not passed to a doctor until 5th October. [Dr C] requested her core trainee to see Abbi urgently. This did not happen. No explanation has been given to this court as to why. [Dr C] was sufficiently concerned, even with her overwhelming workload, to make an urgent appointment for Abbi on 7th October. It was clear [Dr C] was very concerned when she was informed about the deterioration and that Abbi had not been seen and she acted upon her concerns. Her evidence was that she was working only two days a week in this post with hundreds of patients and only one core trainee at any time. **She was clearly firefighting in an attempt to deal with a virtually impossible workload.** No consultant could cope with her workload.*

[Dr C] was an experienced and is an experienced consultant psychiatrist who was clear in both her actions and her further directions. She had had a short, ten minute meeting with Abbi and persuaded her to take her medication and that this would now require titration. Abbi was not on a large dose of this medication and it would not have taken very long. In the interim, she did prescribe some further medication as a stopgap to assist Abbi. Her evidence was Abbi was already experiencing a deterioration and this was going to get 100 times worse, that she needed to be urgently reviewed if she did not comply. The further directions were given to her core trainee by email. It was quite clear [Dr C] expected Abbi to be reviewed. Unfortunately, these appear in direct emails and were not acted upon. Abbi wanted and she thought she had persuaded Abbi to restart her clozapine. I am satisfied that in the absence of this, that this should have happened but no later than a week after this, there were concerns about Abbi still not having sufficient medication and some diazepam was started. Diazepam, 5 milligrams twice a day, was supposed to be a short-term stopgap to assist Abbi over a period of time. It went on to repeat prescription at the beginning of November. This should not have happened. It was not [Dr C]'s intention. She wanted her and directed her to have a medical review and if she continued to fail to comply, as she did, to have a capacity or Mental Health Act assessment...

I can see no formal assessment took place for Abbi after this time and it is not clear to me, if Abbi could not articulate why she did not want to take her medication, that she did truly understand the consequences of what may happen. There was no discussion that Abbi's quetiapine that had been prescribed was not going to be a long-term solution for her. Dr [I/S] is clear and unequivocal that Abbi's deterioration was not only predictable but it was inevitable and it was going to get worse. [Inaudible] were on notice of it. Quetiapine had been of limited use in the past and I am satisfied Abbi then became increasingly reliant on diazepam and this started to have limited benefit for Abbi.

Abbi started to have hallucinations and was troubled by them and was starting to inform mental health services about this. Abbi started to self-harm and required admission to the acute trust on 23rd January, with prolific self-harming behaviour, in great distress. Abbi had also started to drink alcohol and she had said that this was to manage the very distressing thoughts that she had. This is, of course, maladaptive behaviour and, again, there was no discussion about whether Abbi should return to clozapine or whether she should have an assessment.

Abbi's access to ligature material at the acute trust was not well managed and she managed to ligature multiple times in her admissions in January with her socks. After the first admission, Abbi was subject to a Mental Health Act assessment by Dr [I/S] who happened to be familiar with Abbi. The information he received that Abbi had exhibited some very disturbing behaviour, including defecating, spitting, swinging from light fittings, he thought did not reflect

the Abbi he knew and he took time to question this information within the information provided by the approved mental health professional. He was assured that this was and did relate to Abbi. I note in that document that Abbi's name is not used and the name of another patient is contained within it. Abbi had never exhibited this type of behaviour in the past and Dr [U/S] made his own assessment of Abbi and it is clear to me he did not take this into account. His evidence to me was he was not persuaded by it. He regretted not putting this in his own records because this evidence was then repeated in a letter to Abbi that she found distressing. He found Abbi was calmer and Abbi did inform him that her drinking alcohol was due to her trying to block these distressing thoughts and hallucinations. I am satisfied these had not been troublesome for Abbi on clozapine...

I have heard and prefer the evidence of the ambulance paramedic that he heard comments made from the cubicle about Abbi knocking herself out, although this is disputed by Dr [S]. It is not clear who made the comment but the paramedic, I find, has no reason to report this and I am persuaded that even after the passage of time, he remains confident of the impression he had, even with time to reflect on it. I am satisfied Dr [S] acted appropriately at all times. She applied local and national guidelines in her approach to treating Abbi and Abbi responded well to this approach and this was commended by Dr [A] and Dr [S] was able to assess Abbi as a consequence and that her head injury was examined and there was found to be no serious injury. This was also supported at postmortem. Abbi was then handed over to mental health liaison staff.

I am not satisfied Abbi was appropriately observed or cared for or treated during this time. There was a shortage of staff in the mental health liaison team and I am satisfied that they could not attend to Abbi with a one to one at that time. This was reported and it was agreed by those more senior to the nurse on duty that Abbi would be observed by a member of the trust security staff. This was a male member of staff. Abbi had experienced trauma in the past and there was no consideration of how this might affect her. Also, the instruction was she should not access the toilet alone. It was not clear what the plan was for Abbi to access the toilet with a male member of non-clinical staff. The nurse said that staff would come and take over and pop in and that Abbi could have used the toilet during that time.

I have been provided with and seen a photograph of the male security guard who was observing Abbi that she took on her phone. It appears he may have been sleeping. I have no reports or complaints that Abbi was taking photographs, which is prohibited in hospital, so, on balance, it may well be that he was asleep. **This I will leave the trust to investigate but with Abbi's complex presentation, trauma history, autism and mental health diagnoses with self-harm that was prolific in the context of her trying to end her life and wanting to die, I am not satisfied an unqualified member of security staff was appropriate in all the circumstances.**

Abbi managed to ligature with items of clothing, several times with her socks. There appeared to be no appropriate assessment of Abbi's access to risk items and Abbi accessed the bathroom when she was not supposed to do so alone. I am satisfied that an alert was called and responded to...

Abbi was then transferred to the Linden Centre on the evening of Thursday, 3rd February 2022 on two to one observations...

[Dr [Q], in evidence, explained he undertook a longitudinal review of Abbi during her admission and was dismissive of the diagnosis of simple schizophrenia, saying this simply did not fit the picture and presentation of Abbi and in his view, as an experienced consultant

psychiatrist of decades, that Abbi had emotionally unstable personality disorder. He did not think that clozapine was a good treatment regime. [Dr Q] made this decision with no reference or contact with the Tier 4 unit to understand why, when they had cared for Abbi every day for almost two-and-a-half years and had managed to have success in reducing her suicidal and self-harm and self-injurious behaviour, they had removed the diagnosis. [Dr Q] had a strongly held belief that long admission for emotionally unstable personality disorder patients was not helpful and could exacerbate self-harm. This was shared by the other psychiatrists who gave me evidence. Dr A said that there was no consideration of Abbi as an autistic person or what her diagnosis should be if there had been a longitudinal review...

Abbi had a number of incidents where she tied ligatures then and had two incidents on 10th February. When she first ligatured, she was seen by the GP trainee doctor and said she would not do this again. Her observations were not changed. Several hours later, Abbi had tied another ligature and this time hid behind a large chair in her room and I am satisfied this was to prevent staff from finding her. Abbi had torn her curtains to make a ligature. Again, her levels of observations were not changed but her curtains were removed. The recordkeeping is poor and the issues and rationale not set out well for this. I am satisfied Abbi was attempting to end her life with these ligatures that had to be cut off, was expressing distress and did not want to be alive...

THE CORONER: I was just trying to remember whether the last ligature was on the 11th or the 12th.

MR R Madam, my recollection, and I think Mr [I/S] mentioned this during the inquest as well, I think it was the 12th.

THE CORONER: Yes.

MR R The last one.

THE CORONER: Because, in my note, it is just slightly confused. I am just going to check Mr [I/S]. I can see he is looking at his note.

MR R It is also mentioned, madam, in the ward rounds of the 14th that there was a ligature event over the weekend and the weekend was the 12th and 13th...

I am satisfied, at the time Abbi was discharged on 14th February, that she had not had access to a lot of ligature material or her own possessions.

I am satisfied that her care coordinator did want to be involved with Abbigail. O was very clear and had, at times, stepped up care for Abbi. The stepped up care during her absence was not always effective due to the pressures on the service and sometimes they could not get to Abbi but I am satisfied that O the care coordinator, wanted to be involved, that she had set three criteria to be met to achieve a safe discharge. This was part of the plan...

I am satisfied the preceptorship nurse was told that the home treatment team would not be involved with Abbi as she had a care coordinator. It may well be that this was a communication error and a lack of understanding of the issues between the two teams but I am satisfied that the preceptorship nurse handed over to the treating clinical team on the morning of 14th February that the home treatment team would not be involved with Abbi because she had a care coordinator. I am satisfied that this information was not only correct [sic], that the treating clinical team knew this was incorrect. They knew it was incorrect because of their experience

in discharging from that ward and they knew this because Abbi herself had only just had involvement with the home treatment team with a care coordinator involved and that was what had brought her into hospital. This was the history that she actually came in with and so it was known to them. If it was not known, that was an error on their part. It was in the records and it should have been known but I am satisfied they did know this to be incorrect. They did not seek to have any discussion with [redacted] O

I am satisfied that Abbi still had thoughts, plans to end her life and this had not changed. Simply asking her whether she wanted to end her life or whether she was going to tie another ligature, they knew her answers could not be relied upon even in the days just prior. I am satisfied there was a real and immediate risk that Abbi wanted to take her life. She had disclosed plans to the treating clinical team on, I think it was, the 8th and 9th, but certainly on the 8th, that she wanted to end her life and would do so on discharge. This was not sufficiently explored with Abbi and there was nothing to mitigate this risk that Abbi would take her own life. I am satisfied that this was not a risk simply to harm herself but an expressed plan and intention to end her life and that Abbi had tied at least three ligatures after saying this. She also said she did not want the doctor to be told...

There was no exploration of the ligatures that Abbi had tied after the last ward round on the 9th and there was no plan to protect Abbi or mitigate this risk and she was discharged, She was discharged with five days of her own medication as well. Abbi had a history of taking overdose and that Abbi had previously had her medication managed...

The evidence of the care coordinator was she did not believe this discharge was safe and I accept that evidence. She did make efforts to have discussions with Pavilion Court and she saw Abbi the next day. I am satisfied, whilst there was some discussion about the future, this was minimal and that Abbi disclosed that she wanted to not be here anymore, that she had lived her life and that she did not want to go anymore, could not give any assurances for her safety and was declining help. These were significant when the care coordinator had already thought the three conditions had not been met, one of which that Abbi should be under the home treatment team. No advice was sought from the home treatment team. There may have been a reluctance to do so if they thought that they had refused Abbi already.

I am satisfied that there was discussion between the care coordinator and Pavilion Court. There is a dispute in evidence about precisely what was handed over but I am going to say that Pavilion Court were not primarily responsible or responsible for Abbi's mental health or her risk for her to end her life. They were there to support Abbi and alert concerns.

I am satisfied, on balance, the evidence that was recorded by [redacted] [I/S] in the records and his evidence to this court that [redacted] O was not sure what to do is correct. The care coordinator was left in a very, very difficult position and her actions on that day are consistent with her going back to take advice from the senior members of the team. This was appropriate for her to do. However, there should have also been consideration of an alert in a crisis for the home treatment team. A decision of the team, I am told, the community mental health team, was that they, being nearby, were going to step up Abbi's care. This was not their role and I am satisfied that they could not always achieve it in the past and this plan was not appropriate, in all the circumstances, for Abbi. If the plan was so urgent and important, it was not recorded in the notes until the 16th. I appreciate the meeting may well have gone on for a long time.

I am satisfied that the home treatment team should have been alerted. That was what was handed over by [Dr [redacted] Q] in the discharge. I am not satisfied the discharge was appropriate or

safe in all the circumstances and the community team should not have been left in this position in all the circumstances...

I am satisfied that Abbi was a vulnerable person. It is undisputed she was with her history and I am satisfied that Abbi could not provide or procure the medical attention that she needed for herself. I am also satisfied that Abbi's condition was known to EPUT, that there was a real and immediate risk to her life and that this was known and that the failures to speak with the home treatment team and to speak with the care coordinator, even if they believed Abbi should be discharged, they took no time to put a plan in place for Abbi to try to keep her safe and that Abbi required this and those failures were gross failures to provide or procure basic medical attention for someone in a dependent position who cannot provide it for him or herself and that Abbi was in a dependent position and her condition was obvious.

There was an opportunity to provide or procure the relevant medical attention. Abbi did not need to be discharged immediately on the 14th when she was. They could have attended to these matters. I am not satisfied that the conditions imposed by the clinical team were met or were properly considered and that Abbi did not need to be or should not have been discharged at all with her presenting risk. The home treatment team had no opportunity to have any input at all but even if that was not considered to be necessary, Abbi should not have been discharged when she was. There was no proper assessment of her risk and no proper care plans during her time of her admission from 3rd to 14th February.

So there were failures in Abbi's care. Abbi was not kept safe. Her detention was required to keep her safe with the severity of risk she posed to herself and I am not satisfied that risk was mitigated with the evidence available to the treating team on the ward. Abbi had three ligatures from the 9th, when this plan was first made. This was an escalation of ligature tying because she had not had ligatures in the previous few days and so I am not satisfied that this risk was mitigated. I am not satisfied that these matters were appropriately considered in her discharge. The risk to Abbi's life was known, real and immediate.

There were failures in Abbi's care to provide appropriate adjustments with trained staff for her autism. Abbi was entitled to have care, education and treatment reviews. There was a complete absence of these at all times. Staff involved in Abbi's care, save for Pavilion Court, had no training in autism and there were no reasonable adjustments for Abbi. There was a failure to tailor Abbi's care to take account of her being a neurodiverse person or for Abbi to have any further testing in that regard. I am satisfied there was an opportunity to render and provide and procure care for Abbi that would have avoided her death.

Turning to these, I have considered the questions. Was there or were there failures to provide or procure basic medical attention for Abbi, including basic medical care? The answer is yes. Was Abbi in a dependent position because she was unable to provide or procure such medical attention for herself? The answer is yes. Was Abbi's mental state such that clinical staff knew or ought to have known that she needed such medical attention? The answer is yes. Was there a direct causal connection between the failures and Abbi's death? In other words, if this failure had not occurred and the opportunity to provide care had been taken, would Abbi probably not have died when she did? The answer is yes. If Abbi had not been discharged, she could not have taken her own life when she did. Were the failures so serious they can only be described as gross failures? These failures are basic in this scenario. I have to and must make a distinction between a clinical judgment and diagnosis of a complex medical condition and decisions to prescribe medication would not be described as basic but the discharge still has to be safe. Was there an opportunity of rendering care that would have prevented the death or prolonged Abbi's life? The answer is yes.

Abbi was going to have access to a whole world of ligature material. She was also distressed by the letter she received, which just added to her understanding and the evidence I have that people simply did not care. Abbi was discharged into precisely the same circumstances with precisely the same situation as when she was admitted with no mitigations. Simply being asked on 14th February and answering "no" to was she going to take her own life or tie a ligature was not consistent with what happened on the ward or her responses and actions and these should have been considered..."

252. Other paragraphs of the Coroner's conclusion are not repeated here as I have already mentioned these earlier in the statement by referencing the Record of Inquest. The transcript continue to state the following entries with regard to a Prevention of Future Death reports, which I am awaiting.

"...I am considering a prevention of future death but I have evidence from the Trust. I have heard some evidence from the Trust about some changes and I have evidence that has been provided to me. So some of the things that I may have mentioned in my conclusion may not be extant at this particular time and I said I would allow seven days for any further submissions.

...

I may not be satisfied even with the Oliver McGowan training about the autism and some people clearly have not had it, so that is going to be made. I am somewhat concerned about medication and the failure of the MDT to pick up the medication. These are matters that I have made prevention of future death reports about before. Now, I know you may well turn around and say to me, "But, madam, they were after the event and, because of the passage of time, [I/S] died before" but I need to get some understanding about some of these things. So you have heard some of the things that I felt were inappropriate. The discharge, the records, clearly, I know you will say I have some information about recordkeeping, so this is why I do not want to spend time going through everything...

say I simply am running out of time because of all the late disclosure. I do not want to go into it again. I have to have time to do this but I am not going to be in a position to draft the prevention of future death immediately...

Cygnnet counsel *you have heard what I have said about the records.*

Cygnnet counsel *Yes.*

THE CORONER: *I am concerned about this. I have not had really much information. The issue of the discharge and what was recorded is troublesome to me and the psychology records not being updated. It may well be that those were relied upon by others in reapplying the diagnosis. I will never be sure of that but the risk was certainly there. So I am concerned. I have not had any information about autism from Cygnnet but, clearly, with the addition of Dr [A]'s update, certainly the healthcare provider were on notice that there was evidence before this court that it was not appropriately dealt with. There were no adjustments. So you have heard the evidence as well, so it may well be that you should also be involved in those discussions with the other representatives. ...*

THE CORONER: *Clearly, I was concerned about the recordkeeping. I was concerned about the observations. I was concerned about the ligature material. I have indicated, as I said to you during the inquest, whether or not the observing person was sleeping is a matter I am leaving to the Trust and so we did not hear any more evidence about that, so I have made no finding that he was. So I am not going to make a finding about that but I am concerned about the access to the ligature material and the short staffing and that people with the complexity of*

[I/S] were left with agreement with the Trust in this way that I did not think was appropriate for the complexity of this particular patient, who was actively trying to kill herself. I do understand sometimes, if people are disturbed, that we have that situation but, MSE solicitor do not think you were involved but Ms [I/S] may update you on a matter that came before this court, and I do not know whether it was last year or the year before, where a patient exited out of a window that was not being observed. So I am concerned about this matter..." (Emphasis added)

Impact on my life

253. At the risk of being repetitive, I know that I have already given a commemorative account but there are certain effects on my life at a practical level which I am of the view should be brought to the Inquiry's attention.

254. I have had therapy in order to address how Abbi's death has affected me. However, I think talking therapy is difficult for me to engage with which may be because I am also autistic. I have to find a solution [I/S]. In addition to coping with Abbi's death, I also need therapy specifically for her time in the St Aubyn Centre. There are things from her treatment and her death which absolutely haunt me. I have [I/S] struggling to sleep. I recall being off work for 6/8 weeks when Abbi died and my employers at the time appearing to be very generous and tell me not to worry about my wages. When I went back though I discovered that they had instead applied all of my annual leave to the time I had had off. The inquest itself had an impact on me. I remember being signed off sick for 2 weeks with stress when her inquest was delayed in September 2024.

255. Greg and I had to clear out Abbi's flat as we were told that the staff at Pavillion Court needed to "void" the flat. I will never forget that terminology, it felt like losing Abbi twice. An email was sent to express my upset at their inconsiderate terminology and choice of words and I hope that they think more carefully before speaking to a bereaved person that way again! We hired a van to clear her flat.

256. I struggled to live in our house, I kept seeing Abbi in all the places I knew she had been; standing in the kitchen doorway, standing on the stairs to hug Greg, sitting on the far side of the sofa, sitting on the seat in the garden, pouring bubble bath into the bath and being my bedroom asking me to fix her hair or if her clothes were ok, or in her bedroom. I just saw her everywhere. I managed another year before we put the house up for sale. I didn't even know where we moving to! We have now moved.

257. There are times when it may appear to others that I do manage my day-to-day life. I still work, my relationships were tested, I can still smile, laugh and go out occasionally. What people don't know is that I say goodnight and good morning to Abbi's 'ordament' – as she would correct me if I were to say 'ornament' – (casket) every day, as if she is still here. I sometimes offer her a coffee, I wear her clothes, I wear her jewellery, I have her vacuum cleaner, her TV, her dolphin ornament, her lamp, her DVD's. I surround myself with her belongings to make sure it feels as if she is still here, there is something of hers in every room. No one knows that. I struggle so much to watch TV, there are so many shows that seem to deal with death and dying and I can't look at the TV screen anymore because it is Abbi's face that I see, and I imagine her body being autopsied. My head paints the worst pictures. I watched a drama the other week and a man playing an undertaker had to embalm a body, I looked away. Then I heard him say "It's OK I remember to sew the eyes and mouth shut" I am crying again now just remembering. Greg must have felt me freeze and seen the look on my face, he was frantically researching the internet saying to me "it's ok Lis, that doesn't really happen". The damage was done though; all I could see was Abbi with really crude thick black cotton sewing her eyes and mouth shut with great big crude cross x stitches. It was horrific and

things like this happen all the time. I constantly replay having to view her body and remembering being told to not move the hair from her neck, I remember washing her teddy (Rocky) that had accompanied her everywhere from childhood, though all her inpatient settings and having to wash and brush him to put him in her coffin next to her so that they could take that final journey together. I remember the undertaker asking permission to embalm her and having to apologise for not being able to get me a full fingerprint because her fingers had degraded so much and them trying to explain how hair changes after death and how they would struggle to wash it but that they would try for me because of all the brambles still in her lovely blonde hair.

258. I think I will have to stop now. I am really crying and Greg isn't here to calm me down, he is training today. My chest is killing me because of the lump in it (from when you try not to cry or end up getting too distressed).

Conclusion

259. I would like to conclude this statement with the following information:

260. The document I created on 11.09.2017 states:

"...You may think that none of this information is relevant or that I have gone into too much depth but allow me to please explain my reasoning.

My daughter was less than 3 years old when she was diagnosed with learning difficulties and she was 10.5 when diagnosed with autism. Her whole life has been a battle with various authorities and professional bodies in order to provide Abbi with the correct diagnosis and then the most appropriate support. This has continued her entire life thus far.

My one and only goal is for my daughter to enjoy her life. I want her to have the most appropriate support in order to fully engage in society and live a life that provides her with safety, enjoyment, fun, love and happiness. Life is fickle and she will of course experience sadness, disappointment and upset, as we all do. However, I want her to receive the tools to arm herself with the appropriate responses to the latter difficulties that she will experience and Mental Health Units are not providing her with this. I wish to have it on record that Mental Health Units have damaged Abbi's fragile mental health and persona beyond recognition. It is vitally important that she is not placed again in these units that threaten her life. She requires support to engage with life and yet these units are merely holding facilities that provide her with no hope and no tools for the future.

Abbi's one dearest wish is that she lives in accommodation where she is allowed to keep a pet dog. This doesn't seem too much to want in life and there must be a way that authorities are able to support her in achieving this goal. I understand that this cannot be an overnight process and I also understand that Abbi is very keen to be discharged from all units as soon as is possible. My view is that Abbi just needs to be given hope. She needs to realise that an independent and fulfilling life is achievable.

I feel disheartened that there has been no cohesive joint working between the various relevant professional bodies in order to secure Abbi the most appropriate support. She has merely been moved from pillar to post when people cannot understand her. Instead they have exacerbated her mental health difficulties and then moved her on when they have failed her.

You may not be aware that Abbi has now been moved a total of 9 times since September 2015, when she was admitted. How on earth is that providing a holistic and therapeutic environment in which to recover and learn to overcome difficulties? It has felt more like both my daughter

and us, her family, have been punished by the mental health system and I don't think any of us have ever felt supported or cared for.

I am cautiously optimistic about Abbi's placement in Cygnet Beckton. I have no idea why she is in a personality disorder unit as no one has ever taken the time to me to explain what Abbi's difficulties are other than the Autism and Learning Difficulties I know she is diagnosed with. However, now that she is there, I have found the staff to be polite, helpful, understanding and considerate towards the family as much as the individual. I am buoyed by the fact that days out are organised and that Abbi is finally allowed time with her family again - as she has never self harmed with us. It seemed nonsensical that the Christopher Unit would not allow her an overnight stay with us. However, Cygnet have already facilitated this on more than one occasion and I know Abbi has enjoyed those days greatly.

I work full time. I am also a nan, step mother, parent and partner - as well as being Abbi's mum. Once upon a time, I lived my whole life for Abbi and it took years for me to realise that I was damaging us both by doing too much for her. For that reason I am now very definite that I need to make time for everyone in my life - including me. This means that I am now of the opinion that Abbi cannot return home to live. It is imperative that she is supported to achieve independent living and be able to make her own choices in life, rather than have me make them for her.

I will close by reiterating an earlier statement - I love my daughter a great deal, but I have no wish to be her carer. I want to simply be her mum and to enjoy mum and daughter time together and to rebuild our relationship that was so badly damaged by Mental Health Services over so many wasted years..."

261. Below I have included part of an email I sent to Abbi's solicitors (in relation to her tribunal) on 12 February 2018. I am sure that the Inquiry can see from the words in this email, the desperation and exhaustion I was feeling. My email stated:

"...Please find attached the documentation that we discussed. Bear in mind that I did say that the paperwork would be pertinent to Abbi but relate back to when she was much younger. Having read through some of these again, I feel they highlight, that if anything – Abbi has displayed these challenging behaviours her whole life and they are not necessarily to do with her mental health needs.

I almost feel like the NHS is trying to "fix what isn't broken" because they do not understand Abbi and who she is, they do not know what she was like as a child or the person prior to the one they see before them now? They have however, equipped her with the tools for turning to serious self harm as a daily living skill. By virtue of being incarcerated with others displaying this behaviour – Abbi has learnt that this is the only option when faced with uncertainty? Please try and find time to read the enclosed paperwork and I feel you will see what I am trying to say – in that the NHS are punishing Abbi by removing her liberty, because she is a young lady with Autism (I personally think it is Aspergers) and learning difficulties? They don't understand her and so they keep her locked away and in turn, teach her better ways to harm herself. Of course she tries to hurt herself – she has no hope at all. All she wants is a pet and a flat – is that too much to ask? You and I know that she will require support, but doesn't she deserve the opportunity to live life and make mundane choices about which TV channel to watch or what to eat for dinner, the same as the rest of us?...

Abbi's whole life has been a battle and I cannot battle any longer. I am tired and I feel guilty but I cannot fight the system! I tried and it broke me. It broke me to the point of nearly not being able to function myself. I cannot go back to that point and I cannot give Abbi the amount of support that she requires.

I just want to be her mum.

If I may be so bold; with regard to seeking a second opinion for Abbi, please try not to allow the NHS to dictate who should assess her (as they made me do), even though that man told me and I quote "Abbi's autism is your ace card and I do not disagree with the diagnosis" he refuted saying this when questioned by professional and merely backed up what they asked of him and then telephoned me to say that I couldn't go around quoting him!?...

There are others, and I certainly do not want to push for anyone in particular but please let it be someone who understands all of the elements of Abbi's diagnosis; her autism / learning disability / dyspraxia / mental health difficulties (oh and borderline personality disorder, although no one has had the decency to tell me about this diagnosis to my face and Abbi certainly doesn't remember things like that!)

Please help my daughter, I am losing hope. She cannot be incarcerated simply because no one understands her or she isn't what they consider "normal"! Do you know that Abbi has never self-harmed or absconded once, whilst at home on home leave with me and Greg? She hasn't been allowed home leave since October 17 (ish) not even for Christmas (although the unit were very good in at least allowing her day leave), but it is these units that make her feel so low, it is this that needs addressing, she needs to be given hope! She was finally allowed overnight leave this weekend gone, and as predicted, Abbi behaved impeccably with regard to her mental health – as she always does.

However, having said all that I need to ask you something very important. Please don't let Abbi have false hope. I would rather her go in to the tribunal thinking that it was unlikely to go her way and come out on cloud 9 rather than go in with hope and come out so upset that she attempts to do something to herself. That would be her autism not letting her see the bigger picture, and living in the moment - but the unit will see at her mental health not being stable and any progress she has made thus far would be massively compromised! ..."

262. The documents which I had referenced in the above email include:

- Nov 05 Initial Autism Diagnosis letter
- May 06 report by **Dr [I/S]** for Educational Statement
- July 06 letter from **Dr [I/S]**
- July 06 letter from **Dr [I/S]** re Abbi's anxieties
- Aug 06 letter from **Dr [I/S]**
- Dec 07 Essex LA Children with Disability Team initial Assessment
- May 09 Essex LA CAF form for young People
- Oct 11 2nd Autism Diagnosis by Essex LA and intelligence scale
- Nov 14 Essex Occupational Therapy Evaluation of ADL Ability
- Aug 15 Essex Occupational Therapy Discharge Report

263. If the Inquiry would like to see a copy of any of the above letters, I would be happy to provide these.

264. Further documents that I have in my possession are included in the enclosed in Appendix 1.

265. I have stated throughout my statement evidence which I believe the Inquiry should obtain and consider.

Abbi's Suicide Note

266. I would like to end my statement by quoting Abbi's 'Suicide note', dated 14.02.2022. It states:

"So my journey ends here I'm so sorry to all the people I have let down but I can't cope and I can't cope with having schizophrenia I was in bed last night and someone grabbed my wrist during the night and it made me jump out my skin I'm finished and I'm done I've got no fight left in me what so ever I feel drained every time I tie something round my neck they always bring me back and that's not what I want and right now suicide is the only option left for me I'm sick of seeing people and hearing voices I drink to forget I hope when I go I will finally be at peace I don't know why I've deserved this life even as a child I was different jist want to say I love you all so much and I feel like I have no idea who I am as a person I look in the mirror and its just my dad staring right back at me the night terrors for me really got to me because at 3:30 in the morning a man broke in my flat he had a knife it felt so real it was like my mind was still asleep but I remember everything I told the man to go away an leave me alone I shouted help there is someone trying to kill me I locked myself in the bathroom and I thought he had gone but he was still there and he stabbed me and each day got worse I did a food shop and the man was following me round the shop he wanted me to kill myself then I ran out of my flat crying and screaming I was so scared"

Statement of Truth

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

SIGNED

[I/S]

Mrs Lisa Wolff

DATED

10.03.2026

APPENDIX 1

Index to documents included in my possession:

Abbi's diaries

Document
Red A4 folder
Purple 'Pink Cookie' folder
Pink 'Personal Assistant' book
Pink diary with butterflies
Black 'Keep making Magic' notebook
Black 'Abbigail Smith My Dairy'
White diary with owls
Grey / blue 'NOTES' book
'Composition Notebook'
Multicoloured furry diary
Purple 'I'm loveable' book
'All About Me' book
A4 Sketchpad
The Healthy Coping Colouring Book and Journal

Abbi's videos

Video	Dated
23:53pm – Abbi explaining the failings of Galleywood Ward, detailing how she had to support other patients in the ward because staff were not.	09.02.2022
12:09am – Abbi explaining how Galleywood Ward had 'gone downhill', and that she was 'finished with life' and 'got nothing left'.	10.02.2022
09:45am – Abbi explaining that she was told off for supporting another patient and is visibly distressed.	10.02.2022
12:07am – Abbi showing her room, detailing that she had no privacy with no curtains.	13.02.2022
15:25pm – Abbi explaining she has no option but to take her life, recorded whilst she was under section the day prior to her discharge.	13.02.2022
16:45pm – Abbi reading letter from EPUT, recorded the day prior to taking her own life.	14.02.2022

Other evidence from Abbi

Document	Dated
Abbi's suicide note	14.02.2022
Abbi's complaint letter regarding Larkwood	Undated

My contemporaneous notebooks

Document
Black Pi Notebook
Reporter's notebook

My records

Document	Dated
Speech and Language Therapy Report	17.11.2005
Consultant Child Psychiatrist	11.07.2006
Consultant Child Psychiatrist review	27.07.2006
Consultant Child Psychiatrist review	18.08.2006
Children's initial assessment	11.12.2007
Essex County Council localisation review	29.02.2008
Individual Education Plan / Review	15.05.2008
Email from Hylands School to Locality Casework Manager SENCAN	06.06.2008
Essex County Council fourth amended statement of special educational needs	15.08.2008
Specialist Teacher Report	24.01.2008
Individual Education Plan / Review	06.11.2008
Common Assessment Framework (CAF) form	15.05.2009
Unified Transition Plan – Annual Review and PEP	21.09.2009
Neuro-developmental and cognitive assessment	12.10.2011
CPA Review	14.08.2012
CPA Review	25.09.2012
Letter to me from Mental Health Act Administrator re Abbi detained under section 3	01.11.2012
CPA Clinical / Specialist Care Plan	04.11.2012
CPA Review	16.11.2012
CPA Clinical / Specialist Care Plan	17.11.2012

CPA Clinical / Specialist Care Plan	24.11.2012
CPA Review	11.01.2013
Psychiatric Report	13.02.2013
Nursing report for CPA (01.03.2013)	13.02.2013
CPA Review	01.03.2013
St Aubyn Centre Education Department CPA Report	01.03.2013
Letter to At Aubyn Centre requesting Abbi's medical records	13.03.2013
Letter from CQC re concerns re St Aubyn Centre	14.03.2013
Letter from 'Making Experiences Count Administrator' re request for Abbi's records	26.03.2013
Social Circumstances Report from Principal Social Worker to Mental Health Act Administrator for Mental Health Review tribunal	28.03.2013
CPA Report completed by key worker	11.04.2013
CPA Review	15.04.2013
St Aubyn Centre Education Department	15.04.2013
Addendum to social circumstances report	03.05.2013
St Aubyn Centre Education Department CPA Report	21.05.2013
CPA Review	21.05.2013
Letter to me from Department for Work & Pensions re Disability Living Allowance	25.06.2013
Letter from Sir Bob Russell MP to me, and enclosed letter to the St Aubyn Centre re Abbi attending her grandmother's funeral	23.07.2013
Letter from Sir Bob Russel to me, and enclosed letter from Rt Hon Simon Burns MP re decision to not let Abbi attend the funeral	24.07.2013
Letter to me from Rt Hon Simon Burns MP, re Abbi's transfer to Christopher Unit	21.08.2013
Psychiatric report – date of admission 24.09.2013	Undated
Social circumstances report	01.11.2013
CPA Report	22.08.2013
Letter to Abbi from Senior Community Nurse and Advanced Clinical Specialist re learning disability	03.06.2013
Mental Health Act hearings checklist	10.06.2013
Key Worker Report for Mental Health Tribunal Hearing	25.10.2013
Letter to Abbi from Mental Health Act Administrator re section 3 detention	27.11.2013
Mental Health Act hearing checklist and report form	27.11.2013
Linden Centre, Christopher Unit Discharge Plan	24.01.2014

Occupational Therapy Evaluation of ADL Ability	06.11.2014
Occupational Therapy Discharge Report	XX.08.2015
Letter to me from Acting Mental Health Act Administrator re Abbi's transfers	28.10.2015
Tribunal report	24.04.2016
Patient information for section 3 detention 11.11.2015	Undated
Letter to me from Acting Mental Health Act Administrator re section 3 detention	13.11.2015
Social Circumstances Report	25.04.2016
Report prepared by keyworker	26.04.2016
Social Circumstances Report	01.06.2016
Report prepared by keyworker	02.06.2016
Inpatient Care Plan	30.10.2016
Mental Health Tribunal Social Circumstances Report	09.06.2017
In-patient Psychiatric Report For the First Tier Mental Health Review Tribunal	14.06.2017
Email correspondence with Norman Lamb MP	26.06.2017
Care programme Approach Initial Medical Report	01.09.2017
Document I created on 11.09.2017	Undated
CPA minutes	21.03.2018
Amended CPA minutes	19.09.2018
Care Programme Approach Psychology Report	27.02.2019
Care Programme Approach Named Nurse Report	28.02.2019
Care Programme Approach (CPA) Policy Occupational Therapy Progress Report	27.02.2019
Risk Assessment	28.02.2019
Care Programme Approach Subsequent Medical Report	01.03.2019
Care Plan	22.11.2019
Care Review / Care Plan	25.11.2020
Full Blood Count	30.03.2021
Letter to Abbi from Consultant Psychiatrist re follow up appointment	17.08.2021
Letter to Abbi from Essex County Council Learning Disability Team re social worker	27.08.2021
Letter to Dr [I/S] Care review / Care Plan that Abbi reads one of her self-recorded videos	27.01.2022
Letter to Dr [I/S] from Mental Health Liaison Team re referral to Home First Team	28.01.2022
Discharge notification and prescription	11.02.2022

Letter to Abbi from Mental Health Act Office re section 2 discharge	14.02.2022
Condolence letter from Head of Patient Safety Incident Management & Mortality	02.03.2022
Letter of Administration	08.09.2022
Consultant Child Psychiatrist Report re amended statement of special educational needs	Undated
CPA Clinical / Specialist Care Plan	Undated
Manager's Hearing Report	Undated
Statement of Information about the Patient	Undated
A guide for Professionals & Parents / carers of Inpatients at the St Aubyn Centre	Undated
Photo of Larwood rules poster	Undated

Complaint correspondence

Document	Dated
Various complaint correspondence, including written by Abbi and myself. Some documents are undated but the earliest date from Abbi's admission to the St Aubyn Centre in 2012.	Various

Inquest Documents

Document
Record of Inquest
Audio recording
Transcript of day 13 evidence produced by a third party– Coroner's conclusion
Inquest Bundle – Addendum A Redacted - AS PSII Report E204810_Version 2 25.06.2024 - Statement EPUT [I/S] statement - Statement DR [I/S] signed - Policy MANAGING CHALLENGING BEHAVIOURSO F ADULTS AND THE USE OF RESTRICTIVE INTERVENTIONS - Policy EMERGENCY CONTROL OF THE ACUTELY BEHAVIORAL DISTURBED – EXCITED DELIRIUM PATIENT: RAPID TRANQUILISATION ON THE EMERGENCY DEPARTMENT - Statement [I/S] SIGNED 01.08.24 - Statement Dr A Specialist 07.08.2024_Redacted - Statement Dr P 15.10.2024 - Statement of [I/S] (002) 04.03.2022

Inquest Bundle – Addendum B Redacted

- Additional Statement Dr **A** 16.06.2025

Bundle 1 – Witness Statements

- ID Statement – Lisa Wolff – Mother_Redacted
- Statement – **[I/S]** – Paramedic – 04032022_Redacted
- Statement – **[I/S]** – Paramedic – 11032022_Redacted
- Statement – **[I/S]** – Paramedic – 15032022_Redacted
- Statement – **[I/S]** – Paramedic – 21032022_Redacted
- Statement – **[I/S]** – Paramedic – 22032022_Redacted
- Statement – Dr **[I/S]** – ST4 Emergency Medicine – 27062022_Redacted
- Statement – Dr **S** – Consultant in Emergency Medicine – 22062022_Redacted
- Additional statement final – Dr **S** – signed – 10.03.2023_Redacted
- statement – DR **[I/S]** – Speciality Registrar Emergency Medicine – 22062022_Redacted
- Statement – **[I/S]** – Registrar in AE – 22062022_Redacted
- Statement – Dr **[I/S]** – A&E Junior Registrar – 19072022_Redacted
- GP Statement – Dr **[I/S]** – Redacted
- Statement – **[I/S]** – Interim Service Manager – EPUT – signed 10.03.2023_Redacted
- statement – Dr **C** – Consultant Psychiatrist – 23.01.2023 – signed_Redacted
- Statement – Dr **Q** – Locum Consultant Psychiatrist – 12.01.2023 – signed_Redacted
- FINAL SIGNED – Supp St of Dr **Q**
- Statement – **[I/S]** – Mental Health Nurse – EPUT – 08.03.2023_Redacted
- Statement – **[I/S]** – Mental Health nurse – 03.03.2023 – signed_Redacted
- Statement – **[I/S]** – Community Mental Health Nurse – 06.03.2023_Redacted
- PSII report comments – Lisa Wolff – Mother – 01.08.2023_Redacted
- **[I/S]** – signed statement (for disclosure)
- FINAL SIGNED – Dr **C** – AS – overview of historic admissions (002)
- Report by Dr **N** 23 April 2024
- ID Statement

Bundle 2 – Reports & Exhibits

- Final PM report – Dr **[I/S]** – Redacted
- Toxicology Report – Imperial College London_Redacted

• GP Summary_Redacted • ROLE • EPCR – 23.01.2022 – 23.24_Redacted • EPCR – 15.02.2022_Redacted • CAD – 23.01.2022 – 22.44_Redacted • CAD – 23.01.2022 – 23.00_Redacted • CAD – 25.01.2022 – 14.31_Redacted • CAD – 26.01.2022 – 14.43_Redacted • CAD – 26.01.2022 – 15.37_Redacted • CAD – 15.02.2022_Redacted • CAD – 15.02.2022 – 23.20_Redacted • Datix incident reports and investigations – Mid and South Essex trust_Redacted • EEAST PCR 25.01.2022 1 OF 2 • EEAST PCR_26.01.22 2039
Cygnnet Health Records • Cygnnet Health Psychology Documents • Cygnnet Health Records • Cygnnet Health Ward Rounds
East of England Ambulance Service Records
Essex Partnership University NHS Foundation Trust Records • Bundle of Additional Records • Bundle of New Records • Datix Bundle • EPUT Bundle A • EPUT Bundle B • EPUT Bundle C • Indexed Condensed Bundle • PSII Report and Enclosures Bundle • Safety Action Plan
Mid & South Essex Records • Bundle 3 – Medical Records

MTVH

- MTVH Disclosure Bundle

Disclosure obtained during Inquest

- PowerPoint photos of Abbi
- Family Pen Portrait
- Witness Statement of [I/S]
- Stills of Abbi on CCTV
- Text Messages
- Bundle of email correspondence between Dr C, Dr [I/S] O and [I/S] [I/S] in October and November 2021
- Photo of security guard sleeping
- Witness Statement of [I/S]
- Photos of missed calls from Pavillion Court
- MTVH Missing Persons Procedure
- Email enclosing further answers from Dr A
- 2017 CTR Policy (shared by Dr A during his Inquest evidence)
- Family Submissions
- MTVH Submissions
- Cygnet Submissions
- EPUT Submissions
- MSE Submissions