WITNESS STATEMENT OF KOBAD BANKWALA
PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

Introduction

1. I, Kobad Bankwala [DOB [I/S] and address: [I/S] [I/S]], the father of Darian Bankwala [DOB: 3 November 1998, and DOD: 27 December 2020], provide this statement to document Darian's mental health background, care and treatment at EPUT, the circumstances of his death, and its aftermath.

2. This statement is based on my memory, and my legal team's analysis of the documents that they have been provided with in connection with Darian's inquest, civil claim, and this Inquiry.

3. Where there is reference to a medical record, or where medications and appointments are discussed, that information is based on my legal team's review and summary of the medical evidence. I do not cover every detail of Darian's care and treatment (for example, it does not cover every single appointment, MDT review etc.); nor do I suggest by referencing the documents that EPUT's medical records are completely accurate – indeed, I had and still have concerns that his medical records were accessed long after he died, raising concerns in my mind that they were tampered with. I also note here that during and after Darian's admissions, both Heidi and I engaged in a lot of correspondence with EPUT and other services such as the local authorities over e-mail and telephone – in this statement, I do not cover every single e-mail and telephone conversation that we exchanged with them.

4. I also note that in this statement, I will refer to Heidi's messages and e-mails with EPUT because I am dealing substantively with Darian's treatment and our engagement with EPUT, and in any event, Heidi and I will be giving our oral evidence together.

5. I also note here for completeness that I missed the opportunity to provide a commemorative account to the Inquiry as I was repeatedly denied core-participant status by the Inquiry until, after my legal team's repeated representations, I was granted it on 18 March 2025.

Childhood history

Mental health symptoms and education

6. Heidi Bankwala is my wife and Darian's mother. Her Rule 9 response sets out the details of Darian's mental health during childhood; and the related interactions that we as a family had with various authorities. I adopt Heidi's evidence on those points. I make the following additional points from my own perspective.

7. Darian's issues impacted his attendance. I recall being prosecuted for Darian's school absences and receiving a fine for them, which I consider a miscarriage of justice. During the court proceedings, I recall the legal representative for the school acknowledging that we were decent parents and that Darian had genuine difficulties. However, I further recall him stating that he was concerned that we might succeed in defending the case, and that he would do his best to ensure that we were defeated. He then invited us to plead Guilty, indicating that if we did, he would ensure that we only received a fine with no order for costs. I consider that this raises serious concerns about procedural fairness being undermined in circumstances where a vulnerable child and his parents needed help. I reported this matter to Essex County Council as part of my wider concerns about their ineffective handling of Darian's education, safeguarding, and support needs. I do not recall ever receiving a formal response to these concerns.

8. I note that the documents reviewed by my legal team set out some of the following needs assessments by the education authorities for Darian as a child:

    a. 31 July 2008: Darian's school *'recently made a request under the 1996 Education Act for the Local Authority to conduct a statutory assessment'* **[[I/S] Locality Casework Manager, SEN and Children with Additional Needs of Essex County Council letter to [I/S] of Child Health Department].**

    b. 17 September 2008: *'[T]he Education Authority is making a full assessment of Darian's possible special educational needs. We would now like to offer an appointment … 29th September 2008.'* **[GP Records, p.82, Consultant Paediatricians (Community Child Health, Mid Essex NHS) letter to Heidi and Kobad Bankwala].**

    c. 18 September 2008: '*Darian is a child with a variety of needs. He has literacy and numeracy difficulties combined with concentration difficulties which impact on his ability to access the curriculum'*: **[I/S] Educational Psychologist, SEN assessment].**

d. 3 December 2008: *'Unfortunately Darian was DNA'd again for medical advice for statutory assessment. He did not attend the initial appointment on 29th September 2008 and also today on the 19th November 2008. I assume all the details, address and everything is correct. I am returning the notes to yourself for further action. I will not be arranging another appointment.'* **[GP Records, p. 24 - Dr A (Associate Specialist in Community Paediatrics) letter to [I/S] SEN Department].**

9. I note with respect to the entry made on 3 December 2008 above, that Heidi has addressed the reasons for any non-attendance in her Rule 9 response: *'Darian did not want to go to these assessments, whether at school or at the GP. Kobad and I tried to get him to these appointments. We were not offered any reasonable adjustments to enable Darian to attend and participate in such assessments. Instead, it seemed that for the services, the situation was black and white: if you did not turn up to the appointment, you were a no-show.'*

10. On 29 October 2009, Heidi and I were informed by Essex County Council that it had been decided that Darian required a statement to be produced for him to access support at school **[Essex County Council letter Heidi and Kobad Bankwala].**

11. I understand from my legal team's review of the documents that on 4 January 2010 a Special Educational Needs statement was produced **[Amended Statement of SEN, [I/S], SEN Area Manager].**

12. I understand that Darian's GP Records show that in August 2010, a CPA referral was made to CAMHS by [I/S] of South Woodam Ferrers Clinic, which stated that: *'This child has been raised as a concern by school because of his lack of progress and strange behaviours. He has a full statement for general learning difficulties but also social and emotional difficulties. He has had all investigations academically that are possible and has recently completed medical tests to rule out any underlying medical problem. Due to his behaviours it is now felt that he needs some input from CAMHS to help him with his social and emotional difficulties.'* **[CPA referral to CAMHS by [I/S] of South Woodam Ferrers Clinic].**

13. That same document goes on to note that Heidi raised serious concerns about Darian that remained ongoing and unresolved without any treatment: *'… Mum is concerned about the concerns the school has and supports this referral as she wants to get to the bottom of what the problem is and what is causing a barrier to Darians (sic) learning. He is not on medication for anything'*.

14. Even after the SEN statement was produced, for the years that followed, a document dated 12 December 2012 notes that Darian continued to display unusual behaviours which professionals themselves regarded as concerns: *'Darian is statemented for severe learning difficulties. School have several concerns and would like to rule out any health issues that may be contributing to the issue:*

Strange inappropriate behaviour. Immature. Calling out with unrelated things to topic in class. Poor concentration. Low academic ability. Low weight and eating concerns – feels sick when eats and has reflux. Problems forming friendships. Poor sleep at times although goes to bed approx.. 10pm sometimes has nightmares. Older brother also has learning difficulties.' [**Community Paediatricians Referral Form by [I/S] of South Woodham Ferrers Clinic (School Nurse)].**

Children's mental health services

15. Between 2013 and 2015, children's mental health services interacted with Darian's school, with CAHMS referrals, refusals, and then subsequent CAHMS assessments, and I understand he was said to have been assessed by an educational psychologist on 5 February 2013 **[Educational Psychologist Report, [I/S]].** I set some of these interactions and referrals out (which also include notes by professionals of some of the concerns Heidi and I raised with them about Darian's needs and behaviours) in response to Questions 2 to 4 of your Rule 9 request.

16. Darian's records note that he was seen at South Woodham Ferrers Clinic on 15 February 2013 and I am noted to have attended with him following a referral by **[I/S]** who was a school nurse **[South Woodham Ferrers Clinic letter to GP 1 at William Fisher Medical Centre].** The notes state that I reported *'that there were some unusual behaviour (sic) such as random touching things which had to be done in a certain way. Things needed to be touched a certain amount of times'*.

17. I understand that Darian's GP records from 15 February 2013 note that Darian had the following problems: *(1) Learning Difficulties supported by Statement of Special Educational Needs (2) Concerns about Growth (weight) (3) Concerns about Behaviour (obsessive compulsive), (4) Concerns about Social Interaction Skills and Attention.'* **[Dr A letter to GP 1 at William Fisher Medical Centre].**

18. They went on: *'Plan: … (2) I have also mentioned the possibility of referral to Tier II Mental Health Team may be helpful to understand his obsessive compulsive behaviour which was described by Mr Bankwala (3) With permission I will write back to* **[I/S]** *and Mr Bankwala has been suggested to discuss Darian's educational progress and further steps forward in the next annual review which is coming … (5) Mr Bankwala has also been given some school therapy questionnaires to look at his motor skills further.'* **[Dr A letter to GP 1 at William Fisher Medical Centre].**

19. On 1 March 2013, Darian was noted to be '*a complex child with moderate learning difficulties but also has some additional needs which may need to be investigated further'* **[South Woodham Ferrers Clinic letter to Acute Paediatric Team at Broomfield Hospital].**

20. On 11 March 2013, I understand that the CAHMS referral was screened by their gateway service and it was decided by them, despite the concerns raised by us and even by the authorities, that, '*based on the information provided did not meet the necessary criteria for assessment or treatment by Local*

Authority Quadrant Tier 2 or Tier 3 specialist mental health services. It would be useful if you could provide further information regarding this child's mental health concerns and his alleged OCD behaviours. It would also be helpful to have information from Darian's school to support your concerns. You should inform the family and progress this.' **[Letter to Dr A from CAMHS Gateway Screening Team].**

21. On 9 December 2013, I understand that a paediatrics specialist, Specialist Registrar wrote to Darian's GP noting that Darian's presentation was getting worse: *'We have received a recent school letter from the SENCO, [I/S] in October 2013, this states that Darian is working at an extremely low level and despite having a lot of support is struggling to access the curriculum. He also states that his ability to concentrate is very poor and is impacting on his ability to progress academically and that many teachers actually think he is regressing. They also think that in comparison to his peers he appears very immature and is now starting to struggle socially to integrate. They also raised issues about his slim appearance and his poor diet.'* **[[I/S] (Specialist Registrar in Community Paediatrics) Maldon Clinic letter to GP 2 of William Fisher Medical Centre].**

22. In the same letter Specialist Registrar noted that I had previously raised during an appointment with Dr A that some of Darian's *'behaviour can be a bit strange …[and] mentioned that he would stroke his phones and walls and also during class he would randomly get up and touch walls a number of times';* and Specialist Registrar noted that he *'got the impression that [I] would be quite keen for him to be seen by CAMHS as he feels a lot of issues are "coming from his head"'* Notably, Specialist Registrar also noted in this letter that Darian himself had *'said that he often gets an urge to do a particular thing and sometimes he does what his head is telling him and on other occasion (sic) he can ignore it.'*

23. In respect of the professionals' concerns about Darian's weight, I remember professionals essentially suggesting that Heidi and I were starving him. I cannot remember exactly who it was that suggested this, but I think this would probably have been the school nurse as I think this concern was raised by the school. I remember responding to this concern along the lines of, *"Look at his mother – she's had five children, they're all skinny, and the only person in the family with a belly is me."*

24. It was a ridiculous suggestion for them to make, especially when it was Heidi and I who were raising the concerns about Darian's presentation to the doctors and school and asking them for help. I said to them that there could be other issues at play. I was not listened to.

25. The concerns we raised are evident from Darian's GP records – for example, I understand that it was reported on 17 January 2014 that: *'Diet history suggests he has definite food preferences and may not always eat conventional meals. … [mother] says he is quite restless at home'* **[Letter to Dr [I/S] from [I/S], Paediatric Dietician from Community Paediatrics].**

26. I understand that on 11 March 2014, what I assume would have been a further CAMHS referral was screened by CAMHS gateway service and that *'based on the information provided, it [was] passed to the Tier 2 Community Mid Team who [were due to] be in touch with the family shortly to inform them of next steps.'* **[GP Records, p.77, CAMHS Screening Gateway Team to [I/S], School Nurse at South Woodham Ferrers Clinic].** I am not sure about what happened with these CAMHS referrals exactly.

27. On 30 October 2014, Dr A noted Darian's *'problems'* as being: *(1) Learning Difficulties – Supported by Statement of Special Educational Needs, Will be attending Southend College in September 2015 (2) Symptoms of Obsessive Compulsive Behaviour (3) Concerns about Social Interaction and Attention (4) BMI on the 0.4th centile.'* **[Letter to William Fisher Medical Centre from Dr A].**

28. Dr A 's management plan on 30 October 2014 noted that Darian was so vulnerable that he needed mine and Heidi's supervision and that he would flag that we needed support: *'(1) I will do another referral to CAMHS Tier 2 in view of an assessment of his obsessive compulsive behaviour … (3) We discussed the management of attention issues which are variable and most likely linked to his educational learning difficulties … (5) Parent has also been advised that in view of his learning educational difficulties he is a very vulnerable lad and this would affect his day to day functioning and he will need appropriate parental supervision (6) Darian will be reviewed in 7-9 months and I will also copy this letter to the school nurse for William de Ferrers School so that the family can receive further advice and support'* **[Letter to William Fisher Medical Centre from Dr A].**

29. I understand that a telephone attendance note contained within EPUT's records states that on 27 November 2014, it was found that Darian had '*been passed over to Tier 2'* with a contact number apparently provided to Heidi and I to contact them **[Telephone note].**

30. On 15 February 2015, an appointment was arranged with [I/S] (a CAMHS Practitioner) for 18 March 2015 at Darian's school *'for the purposes of commencing an assessment of Darian's needs.'* [**Letter to Heidi and Kobad Bankwala from [I/S] Business Support Administrator at Essex County Council].**

31. I understand that [I/S] (Community CAHMS) wrote a letter dated 7 May 2015 to Dr A , stating: *'Following a discussion within the team regarding Darian's presentation we felt that the best service to support Darian at the current time was a counselling service. … We understand Darian has other difficulties and that there is likely to be an impact on his understanding of the stages of adolescent development. However Darian was not keen to explore these difficulties and really wants to fit in at school and not appear different from his peers. We are happy to make a referral to Sycamore Renew Counselling for Darian which is a local young person's counselling service and is free of*

charge.' **[Letter to CAMHS, Dr A (South Woodham Ferrers Clinic) from [I/S] Community CAMHS].**

32. On 10 July 2015, Dr A wrote a letter to Darian's GP noting his *'problems'* as including: *'(1) Learning Difficulties – Supported by Statement of Special Educational Needs, Will be attending Southend College in September 2015 (2) Symptoms of Obsessive Compulsive Behaviour (3) Concerns about Social Interaction and Attention (4) Growth…'* **[Letter to William Fisher Medical Centre from Dr A].**

33. As for Dr A 's management plan on 10 July 2015, his letter states: '*Management plan: … I will copy this letter to CAMHS Tier 2 Services* Community CAMHS *for her information. … I have not offered Darian any further review appointments and he will be discharged from my services and Mr Bankwala is aware that if he has any further concerns regarding Darian (sic). Darian is a vulnerable lad and Mr Bankwala has been given information on Education Healthcare Plan which he needs to look through for on-going support for Darian.*' **[Letter to William Fisher Medical Centre from Dr A].**

34. In his statement for Darian's inquest, Dr J reflected on Darian's childhood presentation and struggles, linking it with those which he faced as an adult: *'From the history provided by Darian's parents, it appeared that from an early age, Darian started to display clinical features suggestive of a developmental Disorder. For instance, Darian has had an inflexible adherence to routines and a ritualized pattern of behaviour, interruption of which led to emotional distress. At a somewhat later stage of development, Darian struggled at school which was manifested in difficulties in developing and maintaining peer relationships and difficulties in academic achievements. Darian was bullied in school throughout…. These adverse experiences in a formative period of his life, affected his personality development including his self-esteem.'* **[Dr J statement].**

Mental health deterioration before February 2020 admission

35. When Darian left college at 19 years old, he wanted to get a job a Domino's Pizza. Heidi and I felt this would have been too much for Darian to take on at that stage, as he would need to write and calculate things very quickly. We felt he might get overwhelmed by this because Darian's illness was such that he was still struggling.

36. Unfortunately, things got worse when Darian befriended someone [I/S] [I/S]. They met from living close to each other although I am not sure when they met. Heidi and I believed that this friend might have been unwell mentally. Darian would disappear sometimes to London and other times, he would just not come home at all. I considered that Darian was very vulnerable and was at risk of abuse, particularly when he was away from home.

2019

37. In 2019, Darian's situation escalated further. Heidi's Rule 9 response sets out a more detailed history of some of the incidents during this time, and Darian's presentation.

38. It was also during this time that the Department for Work and Pensions were placing undue pressure on Darian, and not taking into account his extreme vulnerabilities. I would go so far as to say that during this period, the DWP work coach that was assigned to Darian was bullying him. Despite Darian's clearly vulnerable mental state, he repeatedly told Darian that *"he must go to work",* and repeatedly stopped his benefits at times without explanation or any due process. I recall that at one point, the psychological pressure that DWP placed on Darian was so severe that Darian collapsed. This situation did not improve even when Darian was sectioned later – the DWP officials continued to insist that he attended his appointments with them in person despite how unwell he was. At one point, Darian was in hospital and I said to the DWP words to the effect of, *"[I]f you are so desperate to interview him then go to hospital and do so.*" Heidi and I were eventually forced by this situation to become Darian's appointees, and this was with great difficulty.

39. I understand that there was an intelligence report on 20 July 2019 where a British Transport Police ("BTP") officer *'had noted Darian had been sat at Southminster station for a long period of time.'* **BTP officer statement].** I understand that the report made by the officer noted that Darian *'was stopped due to concerns for his welfare as he had been sat at the station for over 2 hours. Officers on scene suggested that it was clear from speaking to Darian BANKWALA, that he suffers from mental health & learning difficulties however no other concerns.'* **[BTP Fatality Review].** Darian is said by the report to have told the officer that *'he regularly attends the local station or park as there is very little else to do in the area.'* **[BTP Fatality Review].**

40. I understand that this officer did not raise any risks with anyone about Darian despite the officer themselves reporting that it was clear he had mental health difficulties and despite Darian's disclosure that he was repeatedly presenting at a railway station. This is why the report the officer made for *'information only … was not shared with the BTP Vulnerability Unit'* **BTP officer statement].**

41. In July 2019, the police interacted with Darian having been arrested for a matter that never resulted in any charges. The police advised us that Darian did not appear well due to his presentation, and ought to be detained under Section 136 of the Mental Health Act 1983. Nothing came of this though and he was not detained. Heidi and I tried to get Darian detained but our requests were not upheld. Darian's GP and his nurse said that they were would not detain him.

42. In October 2019, Darian's mental health worsened. His concerning behaviours continued. He was punching himself in the head, pulling his hair out, and refusing to leave his bed, wash, and eat. He started threatening to hang himself and even go so far as to threaten Heidi and I. We kept calling the ambulance and doctors to help and assist us. On each occasion, we were told that Darian had capacity to decide what to do and they were unable to section him.

43. In November 2019, Heidi and I decided to go on a family holiday to Tenerife to mark Darian's 21st Birthday. We struggled to get Darian into the cab with us. At the airport, Darian refused to get on the plane with us. He got out of his seat before the plane took off, and then I could not find him on the plane. He did not like the seat. I asked the air stewardess to assist, and eventually we found him.

44. When we arrived at the hotel, Darian refused to do anything, and he would stay indoors at the hotel. He threatened to jump off the balcony at the hotel. He said that he did not want any birthday presents. He did not want us to sing Happy Birthday to him. He was not washing or showering. When it was time for us to leave the hotel at the end of the trip, Darian refused to leave the room, and he could not pack his clothes away. The hotel threatened to call the police, and the hotel maid helped him to leave the room, which is how we got him out.

45. After we returned home to the UK, Darian started going out to Southend and coming back to the house, but not talking to us. One day, Darian came running into the house and refused to get out of bed. He ripped up the duvet at night. He would leave knives everywhere. He would say that he wanted to see me hanging, and he even held a knife to Heidi. I recall having to make him drop the knife before anything worse happened. Darian lost his temper. Our other son, **CSB** was so worried for his safety that he would lock his own bedroom doors. Heidi and I would check in the night to see if Darian was alright and still alive.

46. I understand that the GP records show a letter dated 6 January 2020 authored by **GP 3** (GP Surgery) to the Community Psychiatrist for Learning Disabilities marked as 'URGENT' and stating:

> *'I would be very grateful for your urgent help, advice and intervention if possible please. … Darian is a very vulnerable young individual, and although would initially appear to have capacity I am really not that sure whether he truly does have capacity and insight into his predicament. He does have learning disabilities and although I really do not feel that he was sectionable today, I am not sure if he has full capacity. His mental health seems to be declining and he does not appear to realise the extent to which his behaviour is becoming more disturbing.*
>
> *His parents and family are obviously very concerned about him as am I; and I would be grateful for your help and advice as to the best way forward; given his background of learning disabilities, obsessive compulsive problems and possible Autism, with worsening issues of*

depression, anger issues and a refusal to give consent or engage with any psychiatric services … Darian himself is unaware I have made this referral.' **[GP 3 letter to Community Psychiatrist for Learning Disabilities].**

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47. Darian's mental health continued to deteriorate. For example, Darian would open the fridge in the kitchen and then say that he did not know what he was doing.

48. On 7 February 2020, Darian was complaining that his legs were falling off and that he had blood coming out of his eyes (there was no such thing happening). Heidi and I used this as an opportunity to persuade Darian to go to the hospital. We told him that we needed to go to the hospital so that they could stop the blood.

49. When we got to the A&E department at Broomfield Hospital, I told the doctors that we were presenting with a mental health problem. I understand that Darian's medical records note that at 23:55 on 7 February 2020: *'The presenting complaint was: not eating / numbness inside / ?mh Triage Assessment: pt states numbness of entire body, has been in bed all week, family concerned, pt not diagnosed with anything from MH side but family concerned'* **[[I/S] (Clinical Practitioner Access Role) at Broomfield Hospital letter to GP 3 (William Fisher Medical Centre) Dated 8 February 2020].**

50. The clinician asked Darian if he felt like harming anyone and Darian answered *"Yes"*. He told the clinician, *"I want to see my dad hanging and I want to kill my mother."* The doctors said that Darian would be sectioned. They said to us that the process would take a couple of hours.

51. I understand that Darian's medical records note that an assessment was carried out by *'RNM* **[I/S]** *and SOT* **[I/S]** *(sic)'* between 03:27 to 04:58: *'He presented as understanding the concepts of confidentiality but to not understanding the assessment process or reason for MH assessment. He was orientated to place. Was not orientated to time presenting as not understanding that it was morning. Presented as not orientated to people in that he was unable to remember the HCA known to the family who had earlier attended to him. He did not present as having the capacity to understand and engage in the assessment process and subsequent outcomes. … Plan: Referred to EDT for MHA assessment [at] 04:58 hours. Referral accepted by EDT. Patient informed. Parents aware and in agreement with referral.'* **[Mental Health Liaison A&E Specialist Assessment Summary].**

52. I understand that a *'Senior / Specialty Review'* during this admission determined that '*… Darian appears to be lacking in insight into his mental state. He has recently threatened parents with a knife, threatening to kill the family cat, standing over parents when they are asleep'*, which led to a plan to*: 'Refer for MHA to be requested; To remain in A&E until further assessed; Police to be called should be abscond.'* **[Handwritten notes, Senior / Speciality Review, Dr [I/S]].**

53. We waited until around 11:00am on 8 February 2020, and another doctor came on shift and questioned Darian, then proceeded to say that Darian was fine and could go home. At 12:41, just five or six hours after being deemed as not presenting '*as having the capacity to understand and engage in the assessment process and subsequent outcomes*' as noted above, Darian was discharged home **[I/S] (Clinical Practitioner Access Role) at Broomfield Hospital letter to GP 3 [I/S] (William Fisher Medical Centre)].**

54. On 9 February 2020, Darian started saying he could see things that were not there and his mental health was worsening. Heidi and I convinced him to go to Chelmsford Hospital to be seen as he was unwell.

55. When we arrived there, Darian was asked if he had any feelings to hurt anyone and he told the doctor that he had thoughts about killing Heidi and I. Darian was referred for a Mental Health Act assessment. After a lengthy assessment by the specialist team, we understood that arrangements were made for Darian to be admitted, however, Darian would need to be seen by another doctor.

56. Heidi and I were told to leave the room as two further doctors arrived. Around 15 minutes later, the doctors told us that they had "*good news*". This was that Darian could be treated from home because he was no longer a danger and he would get the same treatment at home as he would in hospital. Heidi and I pleaded with them to keep Darian in, but they discharged him.

57. I understand that the records from a home visit on 9 February 2020 state: *'Referred for mental health assessment by MHLT, deemed not to meet threshold for formal admission see 135 Paperwork downloaded to referral. Patient depressed, low self worth, unmotivated self isolating, recent cannabis misuse. … Agreed medic review at home tomorrow booked next available emergency slot.'* **[Care Activity note, [I/S]].** With reference to the 'recent cannabis misuse', I did not know about this and I consider that this was made up, as were the rest of the allegations about Darian's drug use during his admission as you will see below.

58. On the morning of 10 February 2020, doctors from the Home First Team came to our house to conduct a home visit. The doctor had to leave the house because Darian had said something to the doctor to upset them. The doctor rang Heidi and told her that Darian should not be at home and that he needed to be picked up from there and that arrangements were being made for him to be collected to be taken to hospital on the following morning. The doctor advised us that that if Darian got worse in the meantime, then to take him to A&E.

59. I understand that the medical records show a subsequent letter dated 18 February 2020 from the treating team on this occasion that: *'Dr* **B** *.. emphasised the need on admission to hospital*

due to lack of insight and non-compliance to medications and this was discussed with his parents in a way to Section him.' **[Letter by Dr C and Dr B].**

60. On the evening of 10 February 2020, Darian got worse. Heidi and I decided to take Darian to the A&E at Chelmsford Hospital. Our two other sons, CSB and AB, bundled Darian into the car and they restrained him during the car journey from our house to the hospital.

61. We arrived at hospital around 22:11 with the presenting complaint as *'mental health issues [and] danger to others'* **[From unspecified individual at Broomfield Hospital letter to GP 3 (William Fisher Medical Centre)].**

62. On our arrival, we were unable to take Darian inside the waiting area. From memory, we were told that it was not safe for Darian to enter the hospital. So we had to wait in the car park. We saw two nurses from the previous admission on 9 February 2020 at Chelmsford Hospital, who told Heidi and I that they had raised an internal complaint about the doctor who had discharged Darian on that occasion, as they knew that Darian would be returning to A&E shortly after discharge. I do not know what came of this complaint but as noted below, I asked for disclosure of these complaints during the Root Cause Analysis stage after Darian's death.

63. The two nurses also said to us that the only way to get Darian detained before an assessment could take place at hospital was to call the police. I cannot remember who called the police, but someone did. Darian had so much strength that our sons needed the assistance of three other staff members, I think they were security staff, to restrain Darian until the police arrived; and during this time Darian continued to physically struggle with all of them as they tried to restrain him. The police arrived. We were told by either the hospital staff or the police that there were no hospital beds available at EPUT, so Darian would need to be taken to a private hospital in Norfolk. The hospital discharged Darian to police custody **[From unspecified individual at Broomfield Hospital letter to GP 3 (William Fisher Medical Centre)].**

64. The police took Darian away from the hospital in their police car, I assume it was to Harlow Police Station because the police said they would take him away and I later saw a reference to this in some documents. I understand that the medical records show that on this day, *'was admitted to hospital under Section 136, following that review he was detained under Section 2 of the Mental Health Act'* **[Letter by Dr C and Dr B].** We, the family, were told to go home. I recall that Darian was detained overnight. I do not know if he received any medical assessment or treatment at Harlow Police Station.

Southern Hill Admission (on behalf of EPUT)

<u>Admission and assessment</u>

65. Darian was admitted to Southern Hill as an NHS patient on 11 February 2020, I understand under Section 2. Again, this is because EPUT did not have any available beds.

66. As for Darian's initial assessment, Southern Hill's notes state that, *'[a]fter presenting with what appeared an acute psychotic episode on admission to the ward appeared calm and a bit anxious. … seen by the duty doctor and we went slowly through the admission process. He admitted to pulling out a knife threatening his mum and denied substance misuse. He said its historical but when asked to do the urine test he refused.'* **[Southern Hill handwritten notes].**

67. I recall speaking to two doctors, Dr D and Dr E. Dr E said that they had oversight of Darian's care and that Darian was extremely unwell and had a very complex case, and that he could be kept in hospital for up to two years as the medication itself could take six months to start to work, and that Darian could not go home under any circumstances and would need a halfway house, in terms of specialist accommodation, when the time to discharge him would eventually come. He mentioned that there were layers of issues that needed to be dealt with slowly, and one at a time. From this time, I asked the health authorities to make sure that whenever Darian was discharged from hospital, that he could not be returned to our house.

68. Heidi and I did not have any input into this admission or the initial assessment.

Hospital environment

69. Although Southern Hill was a private hospital, I have set out the ward environment here because it was contracted out by EPUT to provide Darian's care between 11 February 2020 and 18 April 2020, when he was then moved to the Linden Centre at EPUT.

70. Heidi and I visited Southern Hill almost every day. It was a six-hour round journey for us. We would spend four to six hours with Darian when we were there. I remember Darian complaining to us that he hated it there and that he did not want to be in Norfolk, but that he wanted to be in Essex, Basildon or Southend.

71. The parts of the hospital that I saw were clean. I understood that it was under new management due to prior issues and that a lot of changes had been made generally there. In terms of staffing, I think that they needed more staff, particularly during the nights.

Diagnosis, care and treatment plan

72. Darian never received a conclusive diagnosis at any point. The medical records I received from Darian's Southern Hill admission were very limited and reduced mainly to MDT notes, and require

cross referencing with EPUT records. Southern Hill provided a lengthy report in the inquest procedure that followed Darian's death **[Coroner's Psychiatric Report**], and my question is, where did they get all that information from and could the documents they have pleased be disclosed? I asked for Darian's full records and for his care plan at Southern Hill, but I did not receive this when asked. There was no cooperation with me when I was trying to obtain Darian's care plan. The administrative staff told me that they did not have one, but how could they not have had a record of his care plan?

73. I continue to ask for and seek the original care plan from Southern Hill Hospital, and any further amended care plans – to assess any changes that were made to the care plan, on what clinical basis these changes were made – as I strongly suspect, based on earlier advice that Darian's case was so complex that he would need to be hospitalised for a very long time; and also based on a telephone conversation with a mental health professional there (possibly a nurse or possibly the then Care Coordinator) that I had when the original plan was being put in place that a "blue chip" will be there to ensure that if there is a problem when Darian is discharged then he will go straight back into hospital - that any such changes to the care plan were not based on clinical reasons but on funding reasons. I also request the identification of the individual that spoke to me on the phone and made reference to putting a "blue chip" on Darian's file.

74. Darian was started on 10-minute observations **[Southern Hill Notes, 12 February 2020]**. On 13 February 2020, Heidi and I attended a Multidisciplinary Team meeting ("MDT") which Darian was also at. After the meeting, Darian told Heidi and me that he had attempted to tie a ligature during the night. Southern Hill's notes show that we reported this to them on the same day, and this resulted in increased observations: *'he told his parents that he had attempted to tie a ligature during the night. … Parents concerns were communicated with the RC who suggested observations be increased to every 5 minutes'* **[Southern Hill notes].**

75. Darian was prescribed medication. I understand that the medical records state that on 13 February 2020, an MDT planned that he would be prescribed *'Olanzapine 5mg po nocte [and] Sertraline 50mg po mane'* **[Southern Hill Notes].** I understand that on the same day, another note was made that the plan for Darian was: *'(1) Commence Olanzapine 5mg OD nocte (2) Food and fluid chart (3) Commence Mirtazapine 15mg OD nocte (4) Nursing observations 15 minutes (5) Psychological treatment with* **[I/S]** **[Southern Hill Notes].**

76. On 14 February 2020, it was noted that Darian was refusing to take his medication: *'Darian completely refused his meds this evening'* [**Southern Hill Notes].** Despite this, I understand that on 15 February 2020, his observations were reduced to 15 minutes **[Southern Hill Notes].**

77. On 18 February 2020, it was noted that Darian refused to *'engage in a formalised assessment process'* **[Southern Hill Notes].** It is noted that on 18 February 2020, his diagnosis and difficulties

were noted as: *'(1) possible acute Psychotic Episode (2) Social withdrawal / Anger outburst (3) History of Cannabis use (4) Bizarre behaviours / anxiety. Current medications: Nil'* [**Care Review/Care Plan].**

78. On 19 February 2020, it was noted that *'Darian is reported to have said during a consultant review: "I don't want medication because [?] can be better without medication." "the medication is making me look worse when I'm not"'* **[Southern Hill Notes].**

79. In response to Darian's refusal to take his medication, I understand that the clinicians said to him that they would have to inject him with the medication if he refused to take it. This is outlined in an entry on 21 February 2020: *'[a]greed if he continues to refuse oral medication he will be given Olanzapine injection which was written up on the prescription chart'* **[MDT discussion notes, 21 February 2021].**

80. I understand that there were incidents of violence and further threats by Darian during this admission which show how bad his mental health was. I do not remember if we were informed by EPUT about these incidents of violence, but I do remember something about these incidents (EPUT would provide us with very little information about Darian, and we would have to proactively ask for such information) – so this could have come from Darian himself or the hospital. For example, EPUT's records state that on 22 February 2020, Darian *'threatened to strangle staff with socks … Kicked the window open and damaged the handle … He had to be moved to another room for his safety'* **[MDT discussion notes, 2 April 2020]** and on 23 February 2020, it was reported that he *'knocked the window breaking the [?] … and kicked the rubbish bin and stopped' which caused an alarm to be raised with staff attendance, and 'due to high levels of agitat[ion] … took oral PRN lorazepam 2mg at 07:30 hrs and was asked to move into the quiet room'* [**Southern Hill Notes].**

81. On 24 February 2020, Southern Hill staff reported that *'Darian said that he has tried medication in the past but it hadn't helped (however, his parents stated that they didn't believe he had taken it). Darian was advised that he had been prescribed medication in tablet and IM form and due to his section 2 status he would not be able to choose not to take it. … Darian said that this is unfair as it is making him worse and causing him to want to hurt staff and damage property.'* [**Southern Hill Notes].**

82. On 25 February 2020, the working diagnosis remained the same, and the management plan was to refer Darian for a Mental Health Act assessment **[Care Plan, Dr C].**

83. On 26 February 2020, Darian's medication plan was changed in that Olanzapine was increased to 75mg and Mirtazapine was increased to 30mg **[Southern Hill Notes].**

84. On 28 February 2020, Heidi and I were informed that a Mental Health Act assessment was to take place, requested by Dr D as the 28-day time limit for Section 2 was approaching **[MDT discussion notes, 28 February 2020].** Darian was re-assessed and detained under Section 3. Heidi and I agreed with this decision – we wanted them to help Darian, and to fix him.

85. On 5 March 2020, I informed the staff at Southern Hill that Darian was planning to end his life there. I understand that it was recorded by staff at 18:40 that I spoke with them and *'expressed concerns that Darian is planning to commit suicide in the ward.'* **[Southern Hill Notes].** The notes go on to say, from the staff's perspective: *'I have reassured him that Darian is under observations and will not be able to carry out such plans. Plan: … Inform nursing / kitchen staff to be watchful for blades/knifes (sic)'* **[Southern Hill Notes].**

86. On 6 March 2020, I understand that Darian's Mirtazapine was increased to 45mg once daily, and his Olanzapine to 10mg once daily **[Dr D statement].**

87. Darian's detention under Section 3 is reported to have started on 9 March 2020 **[Independent Mental Health Advocacy Referral Form].**

88. By 12 March 2020, Darian was still refusing to take his medication, and it is reported that he was *'accepting his medication only after threats of injection.'* **[MDT meeting notes, 12 March 2020].** On the same day, it is noted that either Heidi or myself *'volunteered he is suffering from Asperger's.'* I understand that the records state that he refused *'the Asperger questionnaire from the psychologist'* **[MDT meeting notes, 12 March 2020].** I consider that the clinicians did very little to get Darian to engage with the questionnaire or to find another way to assess whether he had Asperger's or autism; instead they did very little in this regard and did the opposite of what would be help, for example by saying things to him about this that would make him angry and disengage.

89. On 20 March 2020, Darian's changed diagnoses and treatment plan were noted as: *'(sic) ?Autism Spectrum Disorder; Depressive disorder with psychotic symptoms; Cannabis substance misuse; Learning Disability … Medication / use of PRN, Olanzapine 10mg PO OD, Mirtazapine 45mg PO OD, Zopiclone 7.5mg, Promethazine 25mg, Lorazepam 2mg … MDT discussion: … It was suggested that this may not be the right setting for him and he may need specialist placement.'* **[MDT meeting notes, 20 March 2020].**

90. There were a lot of communications about Aspergers between us as Darian's family and those treating him. They were educating us about what Darian may have, and we were telling them to do whatever they needed to do to help him. We did not understand what was going on inside Darian's head. At that time, Heidi and I did not understand mental health the way we do now.

91. I understand that Darian's medical records note that in mid-March 2020, the Occupational Therapy team were noted: *'to commence formalised assessment process shortly. A range of OT specific assessments will be completed with a view to developing an OT specific care plan.'* **[MDT meeting notes, 26 March 2020].**

92. On 2 April 2020, further changes to Darian's medication plan were documented on his MDT meeting notes: *'Olanzapine 10mg PO OD, Mirtazapine 45mg PO OD, PRN Zopiclone 7.5mg, PRN Promethazine 25mg and PRN Lorazepam 2mg'* **[MDT meeting notes, 2 April 2020].**

93. This was followed by a further change to Darian's medication on 8 April 2020: *'There was no significant change to his mental state. It was agreed to increase Venlafaxine antidepressant medication from 37.5mg to 75mg once daily to improve his depressive symptoms.'* **[Dr D statement].** This was increased again on 15 April 2020 to 150mg **[Southern Hill Notes].**

94. Overall, some of the care Darian received here was good, but on the other hand, many things should have been done better. I did not understand why the clinicians let him not take medication when he refused. I do not know whether when he was threatened with injections and purportedly complied with taking his medication, whether he actually did take them properly. No one knows for certain whether he did, or whether he was he spitting it out afterwards. I do not know if Darian was supervised properly when taking his medication.

Linden Centre

Transfer from Southern Hill to the Linden Centre on 18 April 2020

95. Darian, Heidi and I made a request for Darian to be moved to a ward in South Essex to be closer to us, but this was not supported by the clinical team. Heidi and I were meant to be given notice about Darian's transfer from Southern Hill when the time would come. Not least because we had raised beforehand that under no circumstances should Darian be transferred to Chelmsford because there was a patient there with whom Darian did not get on. The staff at Southern Hill said to us that this was fine and that they would let us know when he would be transferred.

96. Then, shortly after this agreement, the opposite happened. Darian phoned Heidi and I frantically and said something like, *"They are picking me up and taking me to Chelmsford".* Darian was moved to the Linden Centre in Chelmsford without our consultation, despite the request we had made for him not to be moved there. We were so angry with Southern Hill for doing this and we complained about this. Southern Hill sent us a letter of apology, explaining that that weekend staff at Southern Hill were unaware of the issues we had raised with the hospital about Chelmsford, so they made the decision without that knowledge and without informing us:

> *'…Indeed, there was a plan to contact you on Friday. Unfortunately this telephone conversation did not take place and you received a direct communication about the move from your son himself on Saturday. We apologise for that.'* **[[I/S] e-mail to Kobad Bankwala, 20 April 2020 at 14:28].**

97. In that e-mail, Southern Hill offered us the opportunity to take him back there in the future if they were commissioned to do so by EPUT, but he did not want to be in Norfolk either, so there was no point in pursuing that.

98. Darian's transfer to the Linden Centre (Finchingfield Ward) took place on 18 April 2020 at 14:00 **[Inpatient record - regarding transfer, 23 April 2020].** I was unhappy that Darian had been moved to the Linden Centre. I would have at that time preferred for him to have been transferred to Rochford Hospital or to Southend. Unfortunately, Heidi and I were unable to get Darian re-transferred once he was at the Linden Centre. We tried so hard to do so. Heidi and I were in contact with bed management, which was the department that managed the allocation of hospital beds.

99. Bed management told us that a consultant from Rochford, **Dr H** had intervened and would not allow his transfer there and that the decision to send to Darian to Rochford was not in their hands, nor could they continue to communicate with me about this. I cannot recall how I was told this, but it would have been by e-mail or during a telephone call. I even wrote to bed management to ask them if Darian could get a bed there. I consider that we were being blocked by bed management due to **Dr H** s (the consultant at Rochford Hospital) decision that she did not want Darian to be transferred there. **[I/S]** **[I/S]**

Hospital environment

100. I remember that the Linden Centre was medium in terms of cleanliness but it was very run down. I remember that it was crowded because there were too many people around and it seemed full. Patients would be walking around and I remember feeling that the staff and general controls were poor. Staffing levels were not satisfactory and it seemed to me that they did not care because from my memory they would be sitting around not doing much.

Diagnosis, care and treatment plan

101. As noted above, I will set out what the medical records note about Darian's care and treatment plans, and risk assessments, but note that this does not mean that I concede that these are completely accurate.

102. At the point of transfer, I understand that there were several working differential diagnoses being considered; including Autistic Spectrum Disorder, depressive disorder with psychotic symptoms, cannabis substance misuse (which we did not agree with), and learning disability. I reiterate here that

at no point did Darian ever have a conclusive diagnosis and a treatment plan to reflect a conclusive diagnosis.

103. I was not involved in his mental health or any other medical assessments here.

104. Darian's medical records show that on by 20 April 2020, the plan for him included:

a. *'Ensure 200ml BD, Olanzapine orodispersible 10mg ON, Mirtazapine 45mg ON, Venlafazine XL 150mg ON … in addition to above, currently prescribed the following PRN medications lorazepam PO 1-2mg, max 4mg/24hrs; promethazine PO 25-50mg PRN, max 100mg/24hrs.'* **[Pharmacy Intervention document].**

b. *'Risk plan: To nurse on level 1 observations, 72 hour care plan, Risk assessment, Complete admission paperwork, monitor mental health, To be seen in ward review. c… Management strategy: To nurse on level 1 observations. 72 hour care plan. Risk assessment. Complete admission paperwork. Monitor mental health. To be seen in war review. Ongoing monitoring / communication with Darian, family an[d] professional involved with meeting Darian's needs.'* [**EPUT Bundle 2, p. 33 - Risk Assessment form by Deputy Ward Manager].**

105. On 26 April 2020, Darian was noted to have been *'observed trying to hide medication under his tongue.'* **[Risk Assessment, [I/S]].** The plan was to *'inform the team to be vigilant during meidicaton (sic) time due to hiding medication. Continue to observeon level one (sic).'* **[Risk assessment, [I/S]].**

106. On 28 April 2020, I requested clarification about Darian's diagnosis, and in particular, whether he had schizophrenia or not. We understand that there had been some disagreement between the doctors at Southern Hill Hospital in respect of his diagnosis and treatment plan. I was not given any clear answers in relation to Darian's diagnosis but I was told that the plan going forward was for Darian to be discharged to a halfway house. I asked for a timeline so that plans could be put in place with social services, as Darian would need considerable assistance to live independently. A time-line was not provided at that point so I had acute anxiety about what Darian's diagnosis was, whether and when his section would be lifted, and when he would be discharged. I was desperate to ensure that Darian would not be discharged without adequate support being in place.

107. However, the staff at the Linden Centre just did not want to interact with me. Any communication we had with the staff and clinicians there had to be forced and chased by us. It felt to me that they considered that the less interaction they had with Heidi and I, the better. We were at odds with each other – for example, I remember at times that they would say to us very clearly that they were going to release Darian, and we were often arguing for him not to be released. They were dismissive of our concerns, and they tried to catch us out in discussions.

108. By 28 April 2020, Darian was on general observations (although this may have started sooner than this date) **[Risk assessment, [I/S]].**

109. I understand that the medical records show that the clinicians considered conducting an autism assessment of Darian on 04 May 2020, but decided not to in the end: *'Discussed ASD assessment – [I/S] doesn't think it is an appropriate time for this currently. He came to her group last week – he mentioned that they tried to 'mess with his head' doesn't want any diagnosis, wants to fit in … Dr G – what are we treating? We need to establish a discussion with him – does he have a learning disability, is there a psychotic disorder.'* **[Inpatients document – note of MDT meeting, [I/S]].**

110. On 5 May 2020 at 17:20, I received an e-mail from **[I/S]** (Deputy Ward Manager) in response to communications I had sent, stating:

'…We then spoke to Darion about planning for the future and suggested supportive housing of independent living. However unfortunately Darion did not want to consider this at all and was adamant he wanted to go home and live with you. We explained that you still felt a little fearful following some of his previous behaviour at home and would prefer if he stayed somewhere that could support him for a little while. He was against this idea. Which causes us a bit of a problem, as to be accepted in this alternative housing Darion has to be in agreement.' **[[I/S] (Deputy Ward Manager, Linden Centre) e-mail to Kobad and Heidi Bankwala]]**

111. I replied to this on the same day at 22:12:

'At the hospital in Norfolk we were told that it could take up to six months before the medication starts to have an effect. … We were told by Norfolk that it would be in his best interest that he goes to a half way house before he can come home. We feel that firstly the half way house has to be the right kind and not just any. If you say he needs to stay with us then we need to know what detail support he and us will receive on a daily basis and what that routine will be and what happens if he does not comply.

What is interesting to note that before Darian was sectioned, he stated that this house was the problem and he wanted to move out because that will help him. He use to say that the house was over crowded he has three older brothers living in the house and us two. He needed a place for himself which was quiet and not noisy. He would disappear from his house we had no idea where he would go for days at time. He would sleep rough with tramps and when he did come home, he would not engage with us.

When he was diagnosed with mental health the people who diagnosed him recommended that he immediately be sectioned but the doctor at the hospital said Darian can go home and he can be

treated from home and get the support he needs as if he was in Hospital. When we brought him home one thing leads to another and when another doctor came to see him. This doctor told us that this should never have happened and he needs to go to hospital with immediate effect and that within 24 hours we will be transferred to a hospital. In fact, we ended up taking him back to A&E and the doctors were very annoyed with the doctor who said Darian could be treated from Home. So, we do not want a repeat of the same mistakes been made if you say Darian needs to come home and stay with us.' **[Kobad Bankwala e-mail to Deputy Ward Manager]**

112. On 6 May 2020, Darian is said to have *'attended a Psychology session'* **[Care Activity note].**

113. On the same day, it was reported that: *'There was little or no understanding why he was in hospital … I couldn't find anything in his presentation that would indicate psychotic symptoms at least currently. I tend to think at the moment that he may have an autistic disorder. To what extent there is a mild learning disability is unclear at the moment.'* **[Dr G s Inpatients note].**

114. A psychology *'impression'* was recorded on 7 May 2020, stating: '*Noted therapeutic relationship / rapport building / engagement vital. Diagnostic uncertainty but psychologist thinks social deficits are not related to ASD (neurodevelopmental vs LD vs MH vs personality emergence?). Noted some unusual beliefs. Noted vulnerability. Noted low weight. Noted substance misuse and trauma history. Plan: Feed back to MDT. Take part in professionals meeting. Continue with engagement/relationship building with Darian. Keep in mind the impact of formal assessments on Darian, what a diagnosis may mean for him and his life (does not completing testing preserves sense of self) (sic)'* **[Psychology Intervention note].**

115. On the same day at 11:39, Heidi wrote an e-mail to the clinical team at the Linden Centre stating:

'… As much as I would be prepared to have Darian home, I could not do this without certain conditions being implemented, one of those would be Darians own accommodation, even if that meant in the long run. He would also need counselling/therapy and medication to be enforced if there came a situation whereby he declined his medication. Without these things in place, I feel Darian would end up back in a psychiatric Hospital within a small time frame.

I would also like to point out that Darian has not had the relevant testing for; I.Q and autism. Without this testing, I feel we are all rather in the dark when it comes to putting a relevant care plan in place for Darian. This is an extremely important point as how are we supposed to help him when we don't know how? If he is autistic for example, he may need a very different care plan. Previously, we have been trying to treat Darian without a relevant diagnosis of his condition so I feel we were running around clueless as how best to support him.

Darians previous consultants in Norfolk stated that his health issues were at that time (3 weeks ago) considered as severe to moderate. They said he was an extremely complex case and their early findings were that he was autistic and the psychosis stemmed from the autism. This is why we feel Darians case is unique and complex and there is more to be discovered. Can we please progress with testing Darian for autism and perform an IQ test? These two points are so important as the autism may well have been the catalyst for his mental decline.' **[Heidi Bankwala e-mail to Linden Centre clinical team].**

116. On 20 May 2020, Darian was noted to have complained about the medications he was taking – I also note that whoever wrote this entry spelt his name wrong a few times: *'Darion (sic) said he feels sick and wants to come off the venafaxine (sic) and mirtazpine (sic), he said it makes him feel drousy (sic). Dr G said has the medication done anything positive, he said no. Darion (sic) said that the olanzapine is probably the only one but it does make me feel hungry. It was suggested to titrate the venafaxine (sic) then stop altogether, from 150=75mg then stop.'* **[Ward Review note, 20 May 2020].**

117. On 22 May 2020, it was recorded that Darian *'was unable to problem solve without support'* and that he *'showed some spacial and road awareness although little recognition for those around him.'* The entry goes on to read that Darian *'appeared to lack insight and understanding when discussing some of his recent behaviours before admission'*. There was an action plan here for the *'OT to prepare and complete a full ADL report to assist with possible discharge options'*. **[Inpatients note, [I/S] [I/S]].** As you will read on, this did not happen before his discharge on 7 July 2020.

118. On 25 May 2020, I understand that there was a management strategy for Darian: *'Reduce* 22 *edication*22 *(sic) to 75mg at night with a view to stop. Fridal ADL. 1 hour section 17 leave. Nursed on level 1 observations – reviewed in needs basis. Health promotion – physical health, personal hygiene and nutritional intake. Monitor mental state and behaviour. Promote compliance of medication and psycho education re mental illness. MDT to review weekly. Psychologists to formulate assessment. To be nursed safe and therapeutic environment. Ongoing monitoring / communication with Darian, family and professional involved with meeting Darian's needs. Encourage and promote attendance and participation in group activities.'* **[Ward Review notes, 25 May 2020].**

119. On 30 May 2020, it is reported that *'Darian made threat to another patient with a pencil making throat slicing motion saying that he would kill him. [O]ther patient was really agitated and upset. [D]arian states that the police can't do anything to him because he's under section. [E]xplained by bleep holder that it's not the case. Plan: Increase obs to level 3'* **[Inpatients note, [I/S]].** I understand that the records note that a DATIX was said to be completed that day **[Inpatients note, [I/S]].**

120. The records show DATIX documents about the events on 30 May 2020 dated as updated on 31 May 2020, and these add further detail to this alleged incident: *'[Patient claimed Darian] had earlier on the day threatened to stab him … in the eye with a pencil and made threats to kill him (which was*

documented during the day). Patient … went on to express that he has reported [Darian] to the police but nothing is being done and therefore wants to go home (patient … was reassured that the police have indeed called the ward to confirm his story) … [Darian] has been placed on level 3 when awake on the ward and level 2 when asleep.' **[DATIX documents].** I have not seen this DATIX record, but I remember knowing about it, and I think someone called us to inform us about this police contact.

AWOL incident

121. Darian was allowed to roam around within the hospital grounds unsupervised during his admission here. I think that they were offering Darian unescorted leave for around one hour, but this might be wrong. I recall that the hospital would decide how many times he would be allowed to go on unescorted leave every day. I think every time they gave him leave, he did not return. He would have to take a bus into the town centre he would walk there and back himself.

122. During his time at the Linden Centre, Darian kept saying how easy it was to escape and that the grounds were not secure so he could escape if he wanted to. We told him not to, and we raised our concerns with the staff, but they were dismissive of us and deflected. For example, they would question us when we raised concerns along the lines of*: "What makes you think he would do that?"*

123. Once when Darian escaped from their supervision and went missing, from what Darian told us, he hid behind a tree thinking the staff would run and try find him. But instead, the staff had a cigarette and then went back inside and said they would call the police. So, Darian ran away and changed his clothes somehow. I remember that the staff member's description of Darian to the police was wrong - his clothes were detailed wrong, and his height was detailed wrong. The staff, had they have searched for Darian properly, would have noticed his discarded clothes. But they did not. From my perspective, the team there did not care about him.

124. It was noted on 14 May 2020 that Darian was *'(sic) To vulnerability to go anywhere'* **[Shift Handover Sheet].** Despite this, on 31 May 2020, Darian was able to escape. Documents from Darian's inquest note that on this day, Darian '*climbed under a fence in the garden at roughly 1730hrs… Report Time: 17:34'* **[Missing Report].** How did this happen though if he was on observations and noted as too vulnerable to go anywhere?

125. I understand the EPUT's records show that on 1 June 2020, *'Dr G told him that there are lots of problems at Rochford … Dr G told him that it is unrealistic to go to Rochford.'* **[Ward Review notes, [I/S]].**

126. On 1 June 2020, it is reported at 14:00 that Darian disclosed to staff: *'I feel like shit … I feel like harming myself Im (sic) not going to lie' Unable to tell us how'*. **[Ward Review notes, [I/S]].**

127. Despite this, Darian was again somehow able to go missing. EPUT's note state that on the same day, he was last seen at 17:30, with police informed at 17:35, the clinical manager informed at 18:00, and the Community Mental Health Team informed at 18:10 **[Missing Person Checklist].**

128. A DATIX document was found by my legal representatives in EPUT's records. This is dated as being updated on 2 August 2021 (over one year on from the incident) – it is not clear when the DATIX was first produced and what the update was over one year on. The DATIX shows that Darian had given the staff advance warning that he was going to escape that day*: 'Staff later reported that he had mentioned during the day around 14:00 that he was going to run away.'* **[DATIX document, 2 August 2021].** I was never contacted by EPUT to be informed that my son had told them this at around 14:00 – I only became aware of this information for the first time through the Rule 9 response process. The staff should have known better than to let him escape again, when he had himself told them of his plan to run away.

129. The DATIX details that Darian *'was seen in the garden during the garden break. Staff was in the garden. He was then seen going through the gate in the garden. Alarms were pulled and staff went to find him around the grounds but he had gone. A letter was found in his bed that stated 'I want struggle joe"* **[DATIX document, 2 August 2021].**

130. Darian was not discovered until 3 June 2020 at 02:40, according to the documents reviewed by my legal team. EPUT's documents read: *'the patient was brought back from being absent without leave by police at around 0240hrs … Police informed staff that they had received an anonymous phone call and had been asked to pick the patient up from the streets in a nearby town. The patient was brought back to the ward but became very aggressive and attempted to assault staff and was threatening to kill a fellow patient. The incident was reported to the police and the patient was arrested by police .. a[t] around 09:00hrs and removed from hospital ward.'* **[DATIX document, 2 August 2021].**

131. Heidi has in her statement addressed this incident involving the police. I understand that when Darian was taken to the police station, the police rang the Linden Centre to ask them if Darian had taken his medication, because if he had not, then he could not be interviewed at that stage. The hospital said that he had taken his medication. This was not true. A staff member called **K** admitted this to me on the phone on the evening of 3 June 2020, which I confirmed with EPUT in an e-mail on 4 June 2020 at 00:50 referring to that telephone conversation just hours before my e-mail:

> *'I can confirm that I spoke with* **K** *this evening at the linden centre. She confirmed to me that Darian was not given his usual medication today and that he had only been given tablets to calm him down. … Darian had previously escaped from the linden centre and has therefore not been on his usual medication for some days, this would therefore impair his thinking as he suffers from psychosis. I am not quite sure why a person from the linden centre would say Darian had his usual medication when it can be shown he clearly did not. I feel this was a*

deliberate act to mislead the police to promote a hidden agenda…' **[Kobad Bankwala e-mail to Linden Centre clinical team].**

132. The police matter did not result in any action being taken against Darian in response to the allegations made by the staff against him – this is evident from a crime report produced on 3 June 2020 by the police which reads: *'I have reviewed the CCTV and formed the opinion that this does not amount to Common assault'* **[Crime Report 42/79131/20].** I consider that the staff had engineered a situation to have Darian arrested.

133. When Darian was released from the police station, the Linden Centre said that they would not take Darian back. Darian was therefore transferred to Rochford Hospital, not based on clinical need, but by default because the Linden Centre did not want him.

134. EPUT's medical records from 4 June 2020 note: *'Dr* **G** *has made the decision that Darian needs to remain in hospital at this present time due to recent events which are currently under investigation by Essex Police. It would not be appropriate for Darian to be discharged from section and discharged from hospital to his parents address as they do not want him home and are unable to cope. … Bed management has been updated and have kept Darian on the waiting list for imminent transfer.'* **[Adhoc Telephone Contact note,** **Charge Nurse** **].**

135. I understand from the Root Cause Analysis following Darian's death, that on 4 June 2020, Darian was *'nursed in the Health Based Place of Safety suite, due to the recent incident. A referral was made to the Psychiatric Intensive Care Unit but ultimately the decision was made to transfer Mr B to a different acute treatment ward.'* **[RCA EPUT, p. 24]**

136. At the point of responding to this Rule 9 request, I could not remember being informed about an ICU referral. However, I understand that an e-mail dated 3 June 2020 at 13:05 from myself to the Linden Centre's clinical team states:

> *'…* **[I/S]** *[Charge Nurse] replied that he would probably now go to an ICU and this would teach him a lesson just as being arrested by the Police would hopefully teach him a lesson. My wife pointed out that only two weeks ago Dr* **G** *was talking about releasing Darian as his mental health was getting much better. My wife stated that she couldn't understand what had happened as this was out of character for Darian to behave like this* **Charge Nurse** *replied that he had been ok when he had leave and then he'd escaped and his behaviour had got worse and worse. My wife pointed out that his leave had been taken away as he'd escaped before and that it didn't seem a very secure place,* **Charge Nurse** *'s reply was that nothing was 'fool proof' and that these things happen. This also seemed rather lapse to us, especially as some of these patients are of harm to themselves and others.*

An alarming comment by Charge Nurse *to my wife was this:* Charge Nurse *told my wife that a meeting would take place today whereby it would be decided what would happen to Darian.* Charge Nurse *said Darian may well go to an ICU and it would either be Hadleigh or Chelmsford as they were the only two Hospitals in Essex who had ICU's. She went on to say that Hadleigh was a terrible place as it had a lot of patients from London and if Darian were to go there 'he would not survive!* Charge Nurse *said he would be better placed in the ICU in Chelmsford but she could not be certain that would happen. As you can imagine, my wife was in bits after hearing this. This is not something any parent would wish to hear after they have spent 2 days worried sick looking for their child… I do not feel it would be the right thing to send Darian to an ICU, I feel that it would make him worse.'* **[Kobad Bankwala e-mail to Linden Centre clinical team].**

137. I think someone must have said that Darian needed to go to the psychiatric ICU, but someone else overrode this. I have questions about this entry. Who decided PICU was needed, and why? What happened to the PICU referral? On what clinical basis was it decided that Rochford Hospital was where he should go despite the referral to PICU; and despite Dr G saying on 1 June 2020 that Darian should not go to Rochford – what changed?

138. Before I address Darian's transfer to Rochford Hospital, I would like to make the Inquiry aware that just four months after Darian's continued escapes from the Linden Centre and Heidi and I raising our concerns about this with the Linden Centre, on 19 October 2020, another patient from the Linden Centre escaped and died after he was struck by a train during his AWOL incident. This matter is public knowledge because a Prevention of Future Deaths report, dated 27 January 2023, was published setting this information out.

139. I consider that this is relevant to my Rule 9 and to this Inquiry because I think that had the Linden Centre have taken the concerns of Heidi and I seriously, perhaps Jayden would not have been able to escape as Darian did from the Linden Centre, and maybe he would not have died on that day. The matters of concern raised by HM Area Coroner for Essex in the PFD report at Jayden's inquest included:

'There is a lack of understanding at Essex Partnership NHS Foundation Trust level about the difference between:

… (2)(a) a patient who has been granted section 17 leave under the Mental Health Act who does not return from a period of authorised leave, and (b) a patient who being subject to detention under the Mental Health Act, who has escaped from the confines of the ward and who has not been granted section 17 leave by the Responsible Clinician, and therefore, there is a concern as to how this information is then communicated to emergency services searching for the patient of the risks of self-harm.

(3) Miscommunication between: (a) Essex Partnership NHS Foundation Trust to emergency services, (b) Essex Police to Essex Partnership NHS Foundation Trust, (c) Essex Police to other emergency services. In seeking further information, how a risk managed within the confines of a secure mental health ward may change for an escaped patient and whether there is real and immediate risk of serious or fatal harm to self or others, rather than assumptions that language is being used in the same way by different services.

(4) Lack of an Essex Partnership NHS Foundation Trust senior single point of contact for communications with emergency services who would provide any further information or receive updates and how this could be managed across change of shifts.'

140. In terms of the overall care and treatment of Darian received here, my assessment was and remains very simple: the team made out that Darian was up to mischief and they wanted to get rid of him. Which they did. I consider that there was a genuine conspiracy to demonise Darian and make him look bad. I remember that at one stage, Darian's care-coordinator was changed to **[I/S]** When she was onboarded – she said to me: *"Your son is a piece of shit"* before asking me if I was aware of the things that he was accused of doing. I remember that I said to her that she would learn over time that he was not. As to the actual psychiatric and psychological treatment of Darian, I am not sure beyond what the medical records say, what the treatment plan was.

Transfer to Rochford Hospital on 5 June 2020

141. EPUT's medical records note that on 5 June 2020 at 13:15, the hospital telephoned Heidi to inform her that Darian was going to be transferred to Cedar Ward at Rochford Hospital **[Adhoc Telephone Contact note, Charge Nurse]**.

142. I understand that Darian was transferred from the Linden Centre to Rochford Hospital by ambulance at 16:20 on 5 June 2020, under Section 3, and nursed on level 2 observations **[Form 2.1-00-CP].**

Rochford Hospital

Hospital environment

143. The Root Cause Analysis following Darian's death sets out the ward environment at Rochford. It notes that it was a *'24 bedded adult acute treatment ward with single en-suite bedrooms. Of the 24 beds, there are 2 extra-care rooms on the ward where the highest risk patients can be nursed'* **[RCA report EPUT, 22 January 2021].**

144. I found Rochford to be a bit cleaner, better, and newer than the other two hospitals that Darian was at. Rochford looked to me to be the opposite of what had been portrayed by Dr **G**. When I

arrived there, I questioned to myself what Dr G at the Linden Centre was talking about when he was saying that Rochford was a horrible place.

145. As time went on, I had concerns about the staffing levels here. On 21 June 2020 at 19:18, I e-mailed Dr F and Dr Karale (the same Dr Karale who has provided evidence to this Inquiry on behalf of EPUT), expressing my concerns: *'Further to my previous email today in relation to inadequate staff cover on the first time I rang it was mid-day the second time* [I/S] *answered the phone and he said that he was doing a 1to2 with some one and that there was nobody on the ward who can give me an update on Darian. … this is very alarming and very concerning that due to staff shortage I have no idea how my son has been doing in the hospital today given that on Saturday he had reached an all-time low.'* **[Kobad Bankwala e-mail dated 21 June 2020, 19:18].**

146. I understand that the notes taken by my legal team at the inquest into Darian's death state that one of the staff at Rochford, RMN, gave evidence that: *"Cedar Ward was always busy, not enough staff which is typical of NHS."*

Assessment

147. At Rochford, Darian was under the care of Dr H. [I/S] [I/S] [I/S]

148. I want to say at the outset that Heidi and I had significant problems with Dr H. There are general memories that I have of my interactions with her that I want to set out here. I remember that when Heidi and I were getting concerned about Darian's wellbeing at Rochford, we wanted to speak to Dr H. On a call, shortly into his admission here, I remember that she shouted down the phone to us that, *"There's nothing wrong with your son, he's trying my hospital as a hotel*". I reported this immediately to Care Coordinator.

149. Care Coordinator asked me to attend a meeting to help her with a care plan as there was no care plan – this took place with myself, CC and an individual I assume was her boss. CC told me that we needed to make a care plan. I sat with CC and her colleague for what felt like a few hours, working on the care plan by going through many forms. We were working together on the form where CC was asking me questions about Darian, and I was providing her with the answers. CC said to me, something along the lines of, she needed to *"make sure [she got] this absolutely right and get it correct as otherwise [she would have] another Kobad on [her] hands – and he will cut it down."*

150. I questioned her on what she meant by this. CC said something like, *"I know you enough to know if I make a mistake, you will pick it up immediately, and I know that this is a guy [who I assumed was an individual she needed to pitch the care plan to for costing purposes] who will do the same*

thing here". I considered this to mean that the individual responsible for approving the care plan would cut down the costs by diluting the care plan – I would like to know who this individual was. I even asked her, *"So, he is a loss adjuster?"*

151. At one point during Darian's Rochford admission, a nurse – who I think oversaw the ward - asked me in person, *"What kind of a parent are you who does not want their son back at home?"* I responded that, *"This is not coming from me (Darian needs to stay in hospital), but from the doctor"* – Dr **E** at Southern Hill – who stated to us that he must not return home. The nurse turned her back to me and walked away. I consider that she could only have had that impression of me as a parent from **[I/S]** **Dr H** I do not recall the name of this nurse, but should the Inquiry wish to seek to identify her, I am able to give a physical description.

152. I was often told when I asked to speak to her about Darian's treatment, that she was not in the office. I turned up on one occasion when I was told that she was not there – but she was there. On that occasion, we had a meeting and there was a major argument in which I accused her of lying to us and manipulating us because she said to us that she had not seen my e-mails, but I had been told by her secretary that she had. These are my general memories, but I will detail below some of the specific incidents and issues that I remember regarding **Dr H**

153. As noted above, I will set out what EPUT's medical records say about Darian's care and treatment below, but I do not concede that these are completely accurate. I would also add that, in respect of Darian's care plan, **Dr H** stated in her statement for Darian's inquest: *'A comprehensive care plan for Darian was difficult to agree with him due to his lack of interest. We felt that he needed a comprehensive rehabilitation program including OT activities to improve his daily living skills and 1:1 psychological therapies. … I was aware that he had at the time of admission displayed symptoms suggestions a depression with psychotic symptoms and these symptoms had responded well to a combination treatment with Olanzapine and Mirtazapine. Throughout his stay on Cedar ward, these symptoms had remained in remission.'* **[Dr H statement p. 9/14].** I disagree that his symptoms were in remission – they were active.

154. I note that Darian's discharge summary from the Linden Centre noted that his final diagnosis there was: *'Antisocial Personality Disorder Traits, Possible ASD, Possible LD'* **[Discharge Summary, 5 June 2020, [I/S] to Dr G].**

155. I was not involved in his initial assessment when he arrived at Rochford. I do not know for sure what his observation levels were on arrival, but an EPUT record notes that he was nursed on Level 2 observations on 6 June 2020 **[Continuation Progress Outcome Sheet, [I/S]].**

11 June 2020: Darian is removed from Section and goes AWOL

156. On 11 June 2020, Darian was de-sectioned after his meeting with Dr H I understand that EPUT's medical records from 1 July 2020 say: *'[f]ollowing ward review Darian is now informal patient on Cedar Ward with Open Leave and nursed on general observation on the ward.'* **[Form 2.1-00-CP, 1 July 2020].** I do not remember being told about this by the hospital before he was taken off section.

157. I understand that the care and treatment plan for Darian from 11 June 2020 when he was an informal patient, was: *'nursed on general observation with Open Leave … MDT review weekly … Continue to monitor Mental health state. UDS randomly. Encourage to participate in OT activities. Ensure Darian complies with his medication.'* **[Form 2.1-00-CP, 1 July 2020].**

158. I note that on 11 June 2020, there was a *'[p]lan for accommodation and support to manage in the community'* **[Form 2.1-00-CP, 1 July 2020].** Darian would soon be discharged on 7 July 2020 without any such accommodation or support.

159. Darian had a terrible reaction to his section being lifted and to meeting Dr H. Heidi and I had asked the clinicians, not to use certain phrases and words with Darian because they would act as a trigger for him, but she did exactly the opposite and used those words which triggered Darian, on the same day, to go straight to the train station with an intention to jump in front of an incoming train. Heidi's statement describes the events on that occasion. The particular words that Dr H [I/S] used were that Darian had *'autism'* and was *'mentally unwell'*.

160. In terms of when we might have said this to the clinicians, Heidi had e-mailed Care coordinator on 10 June 2020 at 11:13 stating:

> *'I don't know if you remember the other day, when I told you about how Darian hates to be classed as autistic and that he has said, in the past, he'd kill himself if he ever found out? Well, the other day, after speaking with his consultant (Dr H Rochford Hospital), Darian called me in a huge panic! He said Dr H had told him that he may be autistic! Incidentally, I believe she too, has, on her notes, the information about Darians feelings about being autistic, but anyway, she chose to go ahead with relaying her prognosis to Darian. Like I say Darian called me, saying that he was having an anxiety attack and he seemed pretty distressed at potentially being autistic. I dealt with this by explaining to Darian in quite a lengthy conversation, that if there were 10 psychologists in a room they would likely all come to different conclusions! I explained to Darian that psychology is so broad and complex that sometimes things are left a bit open ended. I went on to explain, that whilst he may tick a few boxes of one condition by one person, it doesn't mean to say that someone else would make a unanimous decision on that finding. I also explained that we're all pretty much on the spectrum to a degree! And I used an example of how, when he was first admitted to Norfolk*

Hospital, one psychologist thought he only had psychosis, another said, just depression and another said schizophrenic (which really scared Darian!)

Anyway, after some considerable time spent explaining to Darian the above, I think I've managed to persuade him to still have assessments done and I explained why they are so useful and important and how they will help get him his aftercare. I also told him that if he really doesn't want to hear what his condition is, maybe he should say to the consultant, that whilst he's happy to be assessed, he doesn't wish to hear about her findings and his condition. I personally think that's a way forward because surely a patient doesn't have to be told that, for example, "You're autistic" or "I think you have schizophrenia". Taking into consideration Darians circumstances, I can't really see the benefit in saying these things to him at this stage, although it maybe beneficial at a later stage.

I know, the other day, we were all pondering on how to get Darian to have these assessments and I think you explained, **CC** *, that one way would be to say, if he doesn't have assessments, he could well be wrongly diagnosed which is also a valid point. Hopefully, together with the information you have above, my thinking was, if you were to meet with Darian next week, you could use some of this information to gently nudge him in the right direction with regards to assessments.*

Sorry it's a bit long winded but I hope the above helps you in relation to understanding Darians mindset and with a view to forging a way forward with him, especially as I know **[I/S]** *did have some issues in this area.'* **[Heidi Bankwala e-mail to** **Care Coordinator**

161. Regarding this incident when he went to the train station, I understand that on 11 June 2020, he was seen *'pacing up and down the platform'* [**Form 2.1-00-CP, 1 July 2020].** Heidi and I were told later that the person who spotted Darian was an EPUT worker at Rochford Hospital. But we were not told their name, so we do not know who they were or what they saw. I think that EPUT kept their identity from us to stop us from speaking to them.

162. BTP's Fatality Review sets this incident out:

'Once Darian BANKWALA had left ROCHFORD HOSPITAL, he had gone to ROCHFORD RAILWAY STATION and stood on the edge of the platform. An off-duty NHS worker has seen Darian BANKWALA and spoken to him and moved him away from the edge of the platform. Rail staff have called police, and upon police arrival Darian BANKWALA was calm and talking to the NHS worker. Darian BANKWALA said to officers that he wanted to jump in front of a train but was too scared to do it. Darian BANKWALA was returned to ROCHFORD HOSPITAL where he was handed over to **RMN** *who he has taken full care and control of Darian BANKWALA'* [**BTP Fatality Review, 12 April 2021**].

163. PC1 transferred Darian back to Rochford. In his statement for Darian's inquest, he noted that he himself had expressed his concerns to the clinical staff there about Darian being de-sectioned. [I/S] PC1 said: *'I liaised directly with* RMN *who informed me that Darian's Doctor was Doctor* G*, I did express my concerns regarding the change of [mental] health detainment, given that Darian had presented himself at ROCHFORD RAILWAY Station on this day, and I was informed that they would be reviewing Darian and deciding on the legal detainment and sectioning of Darian.'* **[PC1 statement, 12 April 2021].**

164. PC2 expressed in his statement for Darian's inquest that on this occasion: *'I did say to the nurse that this needs to be looked at again as he had left at the first opportunity and gone to the railway station to harm himself.'* PC2 **statement, 17 March 2021].**

165. I understand that the BTP's Vulnerability Unit *'who risk assessed the incident and graded it as "High". This was due to the situation and risk Darian presented himself in, the intervention to prevent harm from an unrelated party, the fact he had absconded from the nearby mental health unit as well as the fact this was the first time Darian had come to notice in crisis to BTP and so no previous referrals or actions had been completed.'* **[**BTP officer **statement, 15 July 2021].**

166. Despite the concerns raised by PC1, I understand that Darian's medical records confirm that when he was returned to the ward, he was *'seen in ward round, assessed to be low risk and Section 3 was lifted as he agreed to continue his treatment informally.'* **[Form 2.1-00-CP, 1 July 2020].**

167. I consider that the staff at Rochford did nothing after this incident to protect Darian following this incident and him telling the BTP officer that he wanted to jump on the tracks. It was as if this incident did not happen.

168. I understand that on 12 June 2020, BTP is said to have *'put in place a number of safeguarding measures … to ensue [Darian's] safety'* **[BTP Fatality Review, 12 April 2021].** The following steps are said to have been taken by the BTP: *'Vulnerability Development Officer (IC) has completed the suggested actions: FHQ-PNC-BUREAU were emailed, requesting for a marker to be added to PNC to state that the male is vulnerable; Internal briefing slide was disseminated to BTP officers in the area where Darian BANKWALA presented. Due to the COVID-19 pandemic, VU LDN have implemented skeleton working processes to ensure that the most urgent actions are completed. As a result, on this occasion, the briefing slide has not been uploaded to the BTP Briefing System and a sanitised briefing slide has not been produced; Support pack was sent out to the male's home address of* [I/S] [I/S] *A task was created via NICHE system for the attention of NHS PLT nurses; Further research on male's background was completed and image was obtained through PND system'* **[BTP Fatality Review, 12 April 2021].**

169. I also note that the BTP Fatality Review notes that on 13 June 2020: *'13 June 2020: the NHS PLT nurses conducted a follow up with the care team on Cedar Ward … Care team were advised to update Darian BANKWALA's risk assessment and care plan with BTP's Suicide Prevention Hotline and VU LDN contact details; and asked to contact BTP if there are any future concerns. Darian BANKWALA's (sic) is presently under the care of NHS and linked in to appropriate services therefore risk will continue to be managed and monitored by the care team. Due to high risk behaviour, AS recommended that all SPMH risk actions are completed.'* [**BTP Fatality Review, 12 April 2021**].

170. On 13 June 2020, Heidi e-mailed **Dr H** at 10:53:

> *'Following our conversation today via phone, on Friday whereby you stated that my son, Darian Bankwala needed to "come off sectioning", "stop taking medication" (because he doesn't need it) and where you warned me also that Darian was endangering himself of becoming "institutionalised" for being in a psychiatric hospitals for 3 months.*
>
> *I would like to relay to you the past two days of my life since you told Darian he was free to come and go (knowing full well he had a disorder about being in hospital without sectioning). Added to this whole horrible matter is the fact you told Darian he was autistic when it clearly states in all the notes how he would react to this.*
>
> *Yesterday, Thursday, I went to see Darian (unaware he had been given leave), only to witness him being driven into the hospital via a police car. Apparently, he had been picked up sitting on the platform. Traffic police (who are trained in these matters) picked him up and brought him back to your care. You then decided that, even after this event and others around you saying Darian was unsafe to go out alone, you would carry on with Darian's leave. He was basically free to come and go as he pleased.*
>
> *Today Friday, I picked Darian up from the hospital. He was anxious, unwashed (in fact he smelt really bad), shaking, confused, withdrawn and quiet. I allowed Darian to say nothing and eventually he chatted, ate some food and we also went for a walk. Later, at around 4pm, as I was about to drop him back to the hospital, his father happened to call regarding an email he'd written to you. Darian overheard the call and then started to get anxious and disordered over the fact that he didn't like the correspondence. I tried to calm Darian down but he had a full-blown explosive reaction. He punched my car, tried to poke his eyes out, tied his hand up so tightly it bled, forced his mouth open with his hands, ripped his skin off his fingers, gave himself a nose bleed and much more! He also threatened to knife himself and others and make himself blind, in fact he wished himself blind. In the end I couldn't take anymore and told him off, and I shouted at him in despair that all I wanted was for him to get better and Darian's response was that he can't get himself better at which point he ran off, in his dirty clothes, with dirty long hair, getting drenched in the rain.*

I allowed him some time to calm down before I went looking for him.

At first, I couldn't find him and the police were called, again. Again, I found him at the station and he gave me a death threat look. I encouraged him to get in my car and we went for a drive. Bit by bit I distracted him and we talked about things from the past and eventually I managed to encourage Darian to eat something and also go back to Rochford Hospital. We ended up being late but we did inform staff. I dropped Darian off, he appeared fairly calm and I have just got home, 9.30pm.

As you can imagine, yesterday and today have been exhausting and traumatic. I do feel that this could have been avoided. Darian does not tell the truth about how he is feeling, he doesn't always take medication and recently has become far worse. Even the transport police were amazed that he was being reported missing again when the day before there had been a potential suicide threat and they had to collect him from the station.

I feel my son is being treated like a guinea pig. He has suddenly been given leave and it has been a huge transition for him to take on board in one fell swoop. This process should have been more gradual and it would have been nice if you could have contacted us to update us of his leave as well.

Darian is not capable of making the right decisions, if asked to make decision he struggles badly and often just will not make any decision. What happens if he says I want to be discharged under the current regime you have put him under he will have no place to go as nothing has been as yet been put in place, What will then happen is he will sleep ruff in alley ways has he has done this in the past on many occasions.

I am really concerned about all of the above and the practice that has been put in place. I do need to have a meeting with you Dr H *I really think this would be helpful and beneficial to both of us.'* **[Heidi Bankwala e-mail to** **Dr H** **]**

Incident while on leave on 15 June 2020

171. After Darian's section was lifted, things escalated with him. Heidi faced the brunt of this. As soon as he was taken off section, we said we would take him out during his leave as we did not want him to be alone. It was a nightmare. He was kicking off, kicking the car, and he was out of it. But the hospital staff said to us that there was nothing wrong with him.

172. During these periods, Heidi and I pleaded that Darian should not be let out of the ward on his own and that the staff there should use their sectioning powers to prevent this. But they ignored our pleas and concerns. Instead, they let Darian leave the ward on his own, which led to further incidents. I did

not understand why his section was removed when he had recently been transferred to Rochford from the Linden Centre and when he had gone AWOL having said he wanted to jump on the train tracks and where there was a clear risk to his life. I do not know what the reasons behind these decisions were.

173. On 15 June 2020, I expressed my concerns in writing to **Dr H**:

> *'I feel that the line of communications at present are inadequate and disjointed and blurred which are causing problems between the hospital, ourselves and Darian. The lack of communication also brings [i]n to question Darian's safety and well being. I feel as a starting point a risk assessment needs to be carried out regarding his safety by the hospital involving the social services, the transport police and the Essex police and us as his parents. We can then take the appropriate steps. The improved communications will further help in managing Darian's expectation when the time arrives for his release from Hospital.'* **[Kobad Bankwala's e-mail to Dr H].**

174. At 08:10 on 15 June 2020, I wrote to **Dr H** expressing:

> *'When you told Darian, he was autistic; he rang us up and described what appeared to be a panic attack. We had to calm him down and he appeared to be a little happier but the damage had been done. … The act of Darian going to the station, I believe was due to the fact that you … communicated with Darian in a way which caused him anxiety and confusion. He was unable to process what you had done and said and became a reck. On this occasion, after your interaction, Darian's destruct button had been inadvertently pressed. It is this particular act of going to the station and sitting on the edge of the platform which has never happened before and it is quite honestly a very brutal act for him to consider.*
>
> *You say he is getting better but it is an all-time low. You played the incident down and when I asked you if you had seen the transport police report you gave me a version which was not the full version, you did not tell me that there was an [in]coming train which had to be halted. I can not help feeling that you were economical with the truth. … I asked you to put Darian under section 5 temporarily. If you had done this, we would have had up to 72 hours of breathing space to decide what steps to take next. You belligerently refused this with no explanation as to why. Had you had done what I asked you to do, you would have saved future incidents from occurring.*
>
> *These incidents were extremely traumatic for Darian and what you did was create a new problem and repercussions which I have had to deal with. At times when I spoke to you, I was beginning to question as to whether you were looking at someone else's file you were so far off route in some areas. … As you may not have read the entire file or are unaware of matters,*

in February/March, I asked the consultant to describe Darian's diagnosis and he described it as severe to moderate. He went on to say he was an extremely complex case. There were layers upon layers of problems that needed to be addressed and a lot of time and patience was needed.

Another consultant went further and said it could take up to 6 months before the medication had an effect, and thereafter Darian maybe more open to therapy. I put to you, if he had remained in Norfolk, although he didn't like Norfolk, let us assume the same hospital was in Essex, they would have kept him in hospital for 6 months then reviewed things and possibly kept him in for a further 6 months and thereafter 12 months.

Your comment was "that's a private hospital and they can do what they like". I put to you it's all about the money because all the advice we have been given is that psychosis has to be managed forever and Darian was diagnosed with psychosis so how can he suddenly be cured?

Until yesterday I was under the impression that you got to see Darian every day. I have since learnt you only see him ones a week which means you have seen him only twice and based on this very limited time you had plenty to say, it is for all these above reasons I want a meeting with you and the social services at the same time so that we can work out a gradual release from hospital and act in such a way that it does not freak him out again.' **[Kobad Bankwala's e-mail to Dr H].**

175. At 10:55 on 15 June 2020, Heidi wrote an e-mail to **Dr H** :

'Your own staff are nervous about Darian having leave, I think this is because they spend more time with him than you, therefore they can make a more educated decision as to his wellbeing. I do not dispute that you are educated in your field, however, you do not know my son. To my horror today, I learned that you have spent a maximum of 20 minutes with my son before you made major decisions about his life. Twenty minutes you have spent with my son. He is twenty ones years old, twenty ones years of problems and issues and yet you think you can make decisions about his life and diagnose him after meeting him for all of 20 minutes!!?? Again today I have supported Darian for the 11 hours that you have given him to free fall into anxiety and depression. I have dealt with his moods and problems, questions etc. I listened to the stories and I realised Darian has been let down by the authorities and professionals who are supposed to support him. My stomach is in knots each time I leave my son because I know how volatile and vulnerable he is and I know how much leeway you have given him, this is freedom he does not want or need at this time. Today I had to listen to the in-depth detail of my sons attempt to take his own life. I actually couldn't listen and my husband took over. I still can't bear to hear the details and I won't hear them from anyone. Like I have said in my

previous emails, I believe all this could have been avoided, instead I'm having to scrape the pieces off the floor and this is all because of your wrong choices and diagnosis. I am angry and broken at the same time. I am confused and I have lost faith in professionals such as you Dr H *because I feel Darian has been let down again and again. May I suggest again that you give Darian the time he needs on a section so that he is not a danger to himself and others. Then, introduce leave to him gradually, bit by bit, this is how it should be done. If you cared to look at his notes, you will see so far, every time he has been given leave it has ended in disaster. He wasn't ready for one hours leave and you have him 11 hours.'* **[Heidi Bankwala e-mail to** Dr H **]**

176. At 11:05 on 15 June 2020, I further expressed my further concerns to Dr H as well as warning her of my serious concern that Darian would eventually take his own life:

'We are worried sick and it is driving us out of our minds that if matters are not approached in a different way Darian could end up taking his own life. Our primary concern at the moment is his safety and in light with what's (sic) has been happening recently we are very concern (sic) that his safety is not been considered. We don't think you should be allowing him leave from 10 in the morning till 8 in the evening. We feel that the leave should not be more than a few hours at a time and as a starting point it needs to be accompanied. We feel that you are not taking our concerns seriously which we have brought to your attention and that you are not listening to us. Doctor I know you are under pressure and you are the only doctor on the ward currently and there your work load must be unimgainabel (sic) and on top of it have to deal with six other doctors who report to you. I can see that the conditions exist which lead to mistakes being made and we are very fearful that you have misread and mis understtod (sic) Darian present melt down and that there sis (sic) a high probability you could end up making a mistake and as a result Darian ends up taking his own life.' **[Kobad Bankwala e-mail to** Dr H **].**

177. It is on this day that Darian was again, allowed out of the ward unescorted, located by police sitting in the road, and returned to Rochford. The body-worn footage of the police officer from this day shows Darian's state when he was encountered by the police **[BWV, 15 June 2020].** The police officer described this incident to Dr H when returning Darian to hospital:

Darian was *"[s]itting there, curled up in a ball, right by the moving cars that are coming past, not in the road itself but yeah sitting down, so obviously we stopped to make sure that he's alright and he's said that he's um, yeah suffering from suicidal thoughts at the moment, voices are telling him to do silly things so um, and he's said that he's currently a patient here with yourselves, so I don't know what's going on with him, he hasn't really said to us much…"* **[BWV, 15 June 2020; and transcript of BWV, 15 June 2020].**

178. I was already at hospital this day because I was trying to speak with Dr H. This is when I saw the police turning up at the hospital with Darian. I am seen and heard on the police officer's BWV at hospital, stating: *"… we said "can you please make sure Darian falls under section 5, don't let him go out".* She [Dr H] said, *"no!", and refused to do that … And there were problems after problems after problems, and we're saying why on earth would you leave this [inaudible] out, he's not really fit to go out from 10 in the morning and return at 8 o'clock – and had the doctor acted in a different way – we've gone through hell over the weekend, incident after incident – she said she's not aware of it and she'd check her emails, but she was wrong in letting him loose and we've had to face the consequences."* **[BWV, 15 June 2020; and transcript of BWV, 15 June 2020].**

179. On this day, another police officer expressed concerns to the clinical staff, this time to Dr H herself, about Darian being allowed on unescorted leave. PC3's statement for Darian's inquest reads: *'I believe [it] to be a psychiatric consultant who all stood around us. We conveyed our reason for being there and that Darian was clearly in a bad way and needed help and should not be outside.'* PC3 **statement, 19 March 2021].** I recall hearing Dr H tell the police officer that he was not a doctor, and the police officer responded along the lines of, *"Yes, well, I am a police officer."*

180. I understand that EPUT's records note that on 15 June 2020, Darian: *'Reported experiencing suicidal thoughts. Believes that hospital setting keeping him safe and stable. No attempts made on the ward. Darian stated that he might try to jump in from (sic) of the train again evidence that he wishes not to as he reported not having the courage to act on thoughts'* and yet he was identified by them on this occasion as being at *'Low risk'* **[Form 2.1-00-CP, 1 July 2020].** I was not aware that Darian had told EPUT staff that he wanted to jump in front of the train. No one informed me of this. I consider that Darian did not have capacity and therefore this should not have been a question of *'courage'* for the clinicians. Heidi and I knew that Darian would jump in front of a train. It was not a matter of if, but when. And as you will come to read - he did.

181. I had a brief meeting with Dr H around the time that Darian was returned to the ward by police. She looked agitated. Her hands were shaking. She maintained direct and intense eye contact with me – it felt like she was 'eyeballing' me. I felt threatened by her body language. I was merely raising concerns about Darian's mental health and safety, and the risk that he posed to himself if on unsupervised leave or if discharged. Based on the hostile response I received, it was clear to me that my concerns were not being taken seriously by her or the staff, and that there were significant failures in their communications and engagement with us as a family, and in Darian's safeguarding.

<u>Care, treatment, and engagement with Darian and us after 15 June 2020</u>

182. On 16 June 2020, Dr Karale became involved Darian's care. He gave evidence at Darian's inquest, and in his statement he noted: *'I was first made aware of Mr Darian Bankwala when Dr* H

[I/S], *Clinical Director and Consultant Psychiatrist for Mr Darian Bankwala … contacted me on 16/17 June 2020 via phone seeking advice on Mr Bankwala. … she has not observed any psychotic symptoms in [him] on her ward. I recall Dr* [H] *suggesting that [he] might be on an autistic spectrum disorder. I suggested … that she should seek a second opinion from a Consultant Psychiatrist who specialises in Learning Disability and Autism. I recommended … Dr* [F], *Consultant Psychiatrist for Learning Disabilities to provide a second opinion…I spoke to Dr* [F] *and he agreed to provide a second opinion'* **[Dr Milind Karale statement, 10 May 2021, §§ 2 – 4].**

183. On 16 June 2020, at 10:35am, I e-mailed Dr Karale to raise my fears that Darian would end his own life, and concerns about staffing levels at Rochford:

> *'Due to the Covid situation there has been a breakdown in communications which lead to all sorts of problems regarding my son. We are very worried that due to one reason or another he could end up taking his life. Firstly we would like you to divert more resources to this hospital because I have learnt that Doctor* [H] *is the only one over there and that I believe she is over worked and stretched and there is evidence to suggest that mistakes have been made in matters relating to Darian Bankwala (sic) well being I want you to put some more doctors to prevent a tragedy taking place. I would request that you ask for the file in relation to the concerns we have raised in relation to his safety and also look at what Essex police and the British transport police have to say about this. Your involvement In this matter Is requested and therefore I would be greatly (sic) if you could implement the due process from your side so that you have visibility of what has been going on and what the current state of play. Once you have read that then hopefully you will divert additional resources to prevent a tragedy taking place'* **[Kobad Bankwala e-mail to Dr Karale].**

184. On 17 June 2020, at 07:35am, I expressed my concerns about [Dr H]'s professional conduct, given my concerns as noted in the e-mail:

> *'You failed to manage correctly the handover of Darian's files and notes which should have been transferred to you… You also did not follow the appropriate level of contact with us as agreed when he was hospitalised. … You acted in a manner which aroused suspicion and caused us doubt in your capability and ability to understand and digest Darian's case and fully understand Darian's needs , In this particular case we have found you to be delinquent by not giving Darian the due care and attention which was required by you to provide to him and that we have reasons and evidence to show that in Darian's case you had failed in your duty of care. Your interaction with Darian was such that it caused him confusion and anxiety and was not fit for purpose. The interaction you had with us was of a competitive nature and not of a consultative nature. You clearly presented yourself in an arrogant and dogmatic manner and were hell bent on point scorings exercise to demonstrate your superiority and your approach was one of, you do as I say or there will be trouble. I got the impression that you were not*

used to be challenged and as a result you decided to take a dis like to us, I suppose you were used to having your own way in the past and being challenged did not go down very well with you. I have found that you have been at times economical with the truth. You have tried to mis lead us and you have attempted to deceive us in order to promote your own agenda.…In lifting his section in the way and manner you did was illegitimate; you deliberately applied the wrong test in relation to the mental health act in ordered to support your stance' **[Kobad Bankwala e-mail to Dr H].**

185. On 17 June 2020, Dr Karale responded to my e-mail, stating: *'Following your email, I discussed your concerns with the Director of Mental Health and Executive Director of Operations, particularly your concerns regarding the safety of your son. I have also asked Dr F , Consultant Psychiatrist to review the care and treatment provided to your son and provide a second opinion. … In regards to the medical cover on Cedar ward, I have spoken to Dr H , the consultant for the ward and she is satisfied with the medical cover she has on the ward. The ward has a middle grade doctor and a registrar (ST4-6) in addition to junior doctors.'* **[Dr Karale e-mail to Kobad Bankwala].**

186. I e-mailed Dr Karale to request that Darian sees another consultant, and that Heidi and I would need to meet with that consultant first before they met Darian as there were *'very important aspects which [would] need to be discussed'* **[Kobad Bankwala e-mail to Dr Karale].**

187. At 16:44 on 17 June 2020, I received an e-mail from Dr H 's assistant, stating: *'Dr H [I/S] has asked me to inform you that that Darian is agreeing to stay as an informal patient and therefore does not meet the criteria for a MHA section.'* assistant **e-mail to Kobad Bankwala].**

188. I responded to this at 16:51 on the same day: *'Darian has not agreed to such a thing. In fact due to his disorders he has demanded that he be put back on section. Doctors statement of claim is untrue. … he must be put back on section with immediate effect'* **[Kobad Bankwala e-mail to assistant**

189. I wrote again to Dr H's assistant at 20:22 on the same day:

'There seems to be a miscommunication between Doctor H and Darian in relation to MHA section, he wants to be on one, which is for the time being his coping mechanism. And for doctor H to say he is an informal patient is causing him anxiety and he is unable to cope and process what has been presented to him. It is this that has sent him in to a spin. Section 3 in his head is his safety net. And for the time being we have to go with his safety net … If you say Darian is saying one thing to the doctor and another thing to us, then it is even more important that you use the practice which was applied at Southern Hill, Norfolk. … This process worked fine at Southern Hill hospital when the doctors would speak with us and Darian together to avoid any miscommunications and if doctors needed some help from us in persuading Darian to take steps we would work together. … Whilst it is all very well that Dr

H *says to us that Darian says one thing to us and another to her, she too is doing the same thing, in fact she seems to be following in the footsteps of her patients. I do not know what kind of a show is being run at this Hospital, but it is very clear the left hand does not know what the right hand is doing, there is a lack of communication, there is a lack of supervision of Dr* H *so she is able to do literally what she wants. She bulldozes her way to the staff and operates in an autocratic dictatorial manner. This needs to change, she cannot be allowed to operate in this way with the iron grip that she seems to have over the people that work under her. She is very good at manoeuvrings and manipulating in order to achieve her objectives.'* **[Kobad Bankwala email to** **Dr H assistant].**

190. I understand that on 18 June 2020, Darian was reviewed by Dr F, a consultant psychiatrist for a second opinion. It was noted that Dr F agreed with the decision to discharge Darian from section on the basis, according to Dr F, that there had been no incidents at that point and he did not present with any obvious psychotic and depressive symptoms.

191. On 18 June 2020 at 22:22, I sent an e-mail to EPUT to complain about Dr H and making a request for Darian to be re-sectioned, given that there was a risk to his life:

'There has been a problem with the transfer of files from the other two psychiatric Hospitals which Darian has been to (The Linden Centre, Chelmsford and Southern Hill, Norfolk). Dr H *admitted that she did not read the notes. She has only had two brief consultations with Darian and does not seem to be grasping his complex issues. In these two brief consultations she has made a wrong diagnosis of my son. Also, each time she speaks to him, she upsets him and he takes a huge downturn in mood and has become suicidal immediately after having these consultations with Dr* H.

There is a Police report on the times and dates that Darian has visited the stations for suicidal attempt. She refuses to listen to the serious concerns of us and others within the Hospital. Her stance is, "Its my way or the highway". … The brief conversations we have been allowed to have with Dr H *have been competitive from her side and she seems to be determined to point score. After an incident whereby my son tried to take his life at Rochford Station, we pleaded for Dr* H *to put Darian on Section 5 so that he could be kept safe. Dr* H *refused repeatedly. As a result, Darian went out again and had to be collected from the Station.*

We pleaded again for Dr H *to put Darian back on section but again she refused. The next day, Darian went out again and was returned by Traffic Police for sitting on the side of a Highway, dangerously close. … Darian has given consent that this should be given to us, yet Dr* H *has refused to provide the information requested. She has applied an incorrect test in law to take Darian off Section 3 and make him a voluntary patient. We have told her to*

put him back on Section 3 as this is what Darian wants as he doesn't feel safe. She has refused.

.... So far, the only thing that she has allowed for us to have, is a second opinion. We have since learnt that she has manipulated the second opinion process and therefore once again gone behind are (sic) back in order to tamper with the due process in order to gain an unfair advantage by cheating and using fowl means. … What needs to happen is that doctor (sic) **Dr H** *needs to re-instate the section 3 if not the patient has a very high risk of taking his life. The British transport police are of the same opinion so are the Essex police and we agree with them…*

If section 3 is not implemented then we have somehow have to mange (sic) to keep him alive. If we fail then that is the end of our son if we manage to keep him alive then all that will happen is that once he is out of the hospital within a short period of time he will be sectioned again and will be back in to Rochford hospital and this time for 6 months and more. … It Is requested that all her superiors be made aware of this problem so that they can persuade her to take the right steps in order to save his life.' **[Kobad Bankwala e-mail to EPUT].**

192. At 11:06 on 18 June 2020, I received an e-mail from assistant – which sets out the lack of psychiatrists in post at Cedar Ward (this should be considered alongside the evidence of Dr Karale to this Inquiry about staffing levels at EPUT)*:*

'There are several other doctors working on Cedar ward but they are all working under Dr **H** *'s clinical supervision. None of them has a full specialist recognition in Psychiatry and for this reason, they cannot take over the responsibility for patient care fully independently without consultant supervision; Dr* **H** *holds ultimate medical responsibility for all patients on Cedar ward. There is no other general adult psychiatrist working with inpatients on the Rochford site to whom his inpatient care could be transferred/ Cedar ward operates as a multi professional team including doctors, nurses, occupational therapists, psychologists and physiotherapists. There was a team meeting yesterday, 17.6.20, where every team member agreed that Darian would not benefit from a further inpatient stay on Cedar ward and was ready for discharge. I took the Minutes for this meeting and confirm that this was indeed the case. Dr* **H** *s view that he is ready for discharge is mainly based on the 24/7 observations of the Cedar ward team. You could also contact the ward manager,* **[I/S]** *who was present at the meeting in order to clarify this.'* **[**assistant **email to Kobad Bankwala].**

193. At 12:17pm on 18 June 2020, I asked assistant to clarify the status of Darian's admission: *'Can you please tell us if his status has changed from informal Patient to in patient, and what is the difference between the two.'* **[Kobad Bankwala to** assistant **].**

194. Dr H's assistant responded six minutes later to say: *'I can confirm that [Darian's] status is informal which means he is an informal inpatient and that he has agreed to stay voluntarily on the ward. This is my latest understanding of [Darian's] status. For further clarification and up-to-date information, please contact the ward manager,* **[I/S]** *via our Switchboard on 10702 538000'* **assistant** **e-mail to Kobad Bankwala].**

195. On 18 June 2020, Heidi e-mailed Darian's clinicians at 23:37:

I received a call from doctor **F** *who advised me that he had today spoken to Darian.*

I told him that it was stated that before you speak to Darian you need to have spoken to us first as per the guide lines and the due process which we had implemented with Dr **H** *. Doctor* **F** *said he was not told of this and apologised and stated that had he been made aware, he would have spoken to us first.*
Once again you have attempted to ambush us. Had Dr **F** *spoken to us first, I am certain he would have got a lot more out of Darian and there would have been a lot more clarity. It was very wrong of you to do this despite the procedure we had put in place.*

Whilst Dr **F** *was on the phone speaking to my husband, I had a [S]napchat message from Darian saying that he was out and about in Rochford. I immediately got concerned as when I asked him what he was doing and where he was going, he just answered that he wasn't sure. I could tell he was agitated and I tried to reassure him that everything would be OK. My husband alerted Dr* **F** *that we were very concerned of the wellbeing of Darian, as he was out and about and sounded really miserable. Dr* **F** *said that he would ring the Hospital and inform them of the situation. At this point, I was really concerned so my husband and I drove up to Rochford, this took us about 30 minutes. At this point I could see that Darian (from snapchat) was on the same highway as where he'd been before and been picked up by the Police for sitting in the road. When we arrived at the Hospital, we found that there were 6 people out searching for Darian. They were unable to locate Darian and this was when we joined the search. We found Darian due to snapchat and once he was located, he refused to get in the car but he did say he would meet us at the Hospital, which he did. …*

When my husband asked for another Dr to see Darian, you, Dr **H** *made multiple excuses as to why Darian would not be able to see anyone else, yet other patients are allowed to see another Dr. I see no reason why Darian should not have been allowed this opportunity. Perhaps, you were able to relate more to* **[I/S]** *because she spoke to you in German? Will it help if I tell you my Mother is German; I am half German and Darian is one quarter German? Therefore, this might persuade you to rethink to put Darian back on Section 3.*

Anyway, we took Darian out, walked with him etc. I noticed that his head was bent down a lot today. He barely ate anything all day and I also noticed that he has not changed his clothes now for

some weeks. He really smells terrible and his hair is also very dirty and unkempt. He has started to smoke a lot and keeps going round begging for cigarettes or a light. He hardly uses his phone now or social media. He will go quiet for some considerable time; I believe he is obsessing over things and this is a clear sign that he is going downhill. He has told me that he had not been taking his medication and that some of his medication has been reduced anyway. He reiterated to me that he wants to go back on Section as he does not feel safe. My heart breaks when he says this because I just feel so responsible for him. My prognosis is that Darian will deteriorate more and more and then come back in the next few weeks to need Sectioning in any event. I can see where he is deteriorating to, I've seen it before. My main worry is that he doesn't live to come back on Section because he is so vulnerable right now.

My days and nights are now tormented because I am waiting for that phone call or that Police visit. I am an absolute reck and if there is a death it will be because of you Dr **H** *and one death normally lead to another.*

There is a simple way out of it you except that when you made the decision to get him of section 3 in doing so you did not consider all the material facts and therefore you have errored in your findings and that it was a mistake on your part.

After all you will not have been the first doctor for Darian who has made mistakes and other doctors have had to over turned the previous doctors' decisions and then gone on to make an internal complaint about their own fellow doctor.

The key to this problem Is that al" tha' Is requires is for him to go back on section 3 and then it is reviewed after 4 weeks. It is Darian that is asking this of you, because that will able him to fix himself and move on to the next stage. So please just do it for Darian's sake and all other involved in his wellbeing.' **[Heidi Bankwala e-mail to EPUT clinicians]**

196. I understand that on 19 June 2020, **Dr L** (a clinical psychologist) wrote to **[I/S]** **Dr H** about her psychological assessments of Darian in May 2020. I was not aware of this or even the psychologist's name until the Rule 9 response process. Her letter to **Dr H** included: *'I met with Darian for two psychological assessment sessions on 04.5.20 and 14.05.20. … Recommendations: Further psychological assessment with Darian is required … It is important that Darian is listened to and given a sense of power or control. If Darian consents to IQ and ASD testing this could take place in hospital or the community …Additional formalised assessments could include a HCR-20 risk assessment and personality test to explore mental health presentation and risk of violent to others. This could also help with diagnostic uncertainty. Liaison with the family for more collateral information will be helpful and any previous school / social work reports useful A full ADL assessment will be useful'* **[**[**Dr L** **(Clinical Psychologist, Linden Hospital) to** **[I/S]** **Dr H** **]**.

197. I do not believe that **Dr L** 's suggested approach and steps were taken by **Dr H.**

198. On 19 June 2020, I e-mailed Dr **F** to express my concerns:

> *'You and I have a problem. Darian said yesterday that he does not want to move to Basildon. He has managed to get him self in to another disorder over this and he has deadlocked is disordered brain. This dead lock will now cause him more mental health problems. He seems to have this in his head he needs to have section 3 in place in order to move forward. He says that if section 3 is in place his mind will allow him to fix him self and he will be ready after 4 weeks' time to take further steps and move in to a different accommodation. My wife tells me that he will now start to go down further because he is not on section 3. She has already started to go downhill again and others have also noticed this around him. All with the exception of Doctor* **H.** *The risk (sic) are as follows he has already become a danger to himself and others. The evidence is very clear. So now every time he goes out, we have to rush and keep an eye to make sure we keep him safe.*
>
> *The Essex police and the British Transport Policy will be informed as soon as he is out if he is not accompanied. They do not want him roaming the streets on his own. If you allow this to carry on and even if he is released from hospital we feel that he will have this in his mind that every thing has gone wrong from for him from that point of not being on section 3 and he will detreated (sic) to such an extent that he will end up being in Rochford hospital again , only this time it will be a very long stay. Please note that from the very out set in November he wanted to be in Rochford. Had he had gone straight to Rochford in February by now we all would have seen a different Darian.*
>
> *There is one more legal point I need to bring to your attention. Often it is the case that patients want to be released from hospital and the doctors don't think they should release them. The patient can make a case to the tribunal to determine weather (sic) he can be released or not. Same should have applied to Darian. Darian said he wanted to be on section 3. We should have been allowed to make a case to the tribunal for him to be kept on section 3 because that is what he wanted. We have been denied this process. From a legal point of view the actions doctor* **H.** *has taken is defective. Legally and technically her decision can not stand that section 3 has been lifted with out the tribunals involvement and judgement in this matter.'* **[Kobad Bankwala e-mail to Dr F].**

Incident on 20 June 2020 and care and treatment thereafter

199. On 20 June 2020, Darian was out of hospital grounds on leave, and Heidi was monitoring his location via Snapchat. We called Essex Police because we were concerned for his safety, seeing that he was tracked to the railway.

200. BTP's Fatality Review details this incident, and notes that Darian was intending to end his life in the woods on this day while on leave: '*Darian BANKWALA was calm and compliant and sat down with officers to talk. He stated that he had not been on the tracks and was showing on GPS location there due to the fact that he was on a train from ROCHFORD to RAYLEIGH. When asked why he left he stated that he wanted to go to the woods in RAYLEIGH to hang himself.'* **[BTP Fatality Review, 12 April 2021].**

201. **PC1**'s statement for Darian's inquest adds further details this incident: *'Darian stated he feels confused and then he doesn't know what he is doing, he stated he would* **[I/S]** **[I/S]** *hang himself if he found a woodland to hang himself. … I task one of my [BTP] officers to complete a safeguarding referral due to the actions of DARIAN with a threat to his life … so this would be sent to the [BTP] suicide prevention mental health team to follow up with the hospital and ensure suitable actions were being implemented.'* **[PC1 statement, 12 April 2021].**

202. I understand that following this incident, the BTP's Vulnerability Unit '*who reviewed the incident and through triage, graded the incident and Darian as "High" risk. It was graded as High risk as this was his third presentation in 9 days and in light of his comments regarding alternative methods of suicide.. All previous actions were reviewed and a number of further safeguarding actions were identified and carried out, again as outlined in* **BTP vulnerability manger***'s report.'* **[BTP officer statement, 15 July 2021].**

203. On 20 June 2020, when Darian was returned to EPUT, I understand that a risk assessment was undertaken. Despite just telling officers that he intended to hang himself on this day, and the previous recent incidents noted above, the outcome of EPUT's risk assessment was: *'Utilises leave appropriately. Has absconded from hospital before… Low risk'* **[Form 2.1-00-CP containing Risk Assessment on 20 June 2020, 1 July 2020**].

204. In my view, the assessment and its outcome were rubbish. I questioned the staff about Darian's risks. I argued with them, saying they were incorrect and to change their assessment. EPUT's own records from 20 June 2020 note: *'Family adamant that Darian should be detained under the Section of the Mental Health Act 1983/2007 since he is unable to manage his safety when he is off the ward. Darian … admitted having impulsive behaviour which he tries to control by trying to engage more with peers and staff. He stated that he has a fear for any diagnosis.'* **[Form 2.1-00-CP, 1 July 2020].**

205. On 20 June 2020, a meeting took place where Darian's capacity was assessed. Heidi and I were also present. EPUT's records contain the notes of this assessment in a document called 'Form 16.1'. **Dr H** is named on this, but it was Dr **I** who conducted the assessment – **Dr H** was not there. I will set out my version of this meeting in due course, but take this opportunity to note what Form 16.1 states:

> *'… I have explained the family that Darian has the capacity to make the decision to stay in hospital at the moment; he is not at risk to himself or other at the moment. There is no ground for him to be hold under section 5(2) at this moment. Capacity can be fluctuating., time specific and decision specific and it could be reassessed. Darian's father insisted that there are ground for Darian to be detained with section 5(2) now as he is a risk to himself (going to the train stat[i]on and standing on edge) and risk to family (they have to put things on hold for Darian). Darian's mother described an incident last week then Darian threatened to kill himself and hurt her when they took him out … They insisted that Darian would say the right things to get out of the ward, and then he would go and do the opposite. They insisted that were are taking his word on face value and it should not be like that. … I explained that section 5(2) is holding power and it is not applicable at the moment as Darian is willing to stay in the hospital and he is not posing any rest to self or others at this moment. … I discussed with SpR oncall Dr* **M** *advised to do fully capacity assessment and make a management plan of suspending his leave over the weekend until he is seen by his RC. … Saw the Darian and the family in the family room with SN* **[I/S]** *'* **[Form 16.1, entry on 20 June 2020 at 23:44].**

206. Dr **I** provided a statement for Darian's inquest, in which she wrote: *'After leaving Mr. Darian Bankwala and his family, I called the on call Specialist registrar,* **Dr M** *again and relayed the information I obtained and assessment I had taken. She noted that at present Mr. Darian Bankwala could not be detained under section 5(2) of Mental Health Act, but were he to attempt to leave the ward over the weekend, this would need to be reviewed.* **She** *noted the family's ongoing concerns and indicated that she would speak to them on phone for further discussion and the management plan.'* **[Dr I statement].**

207. My version of the meeting on 20 June 2020 is this. When Darian was brought back to Cedar Ward from Raleigh Station, Heidi and I went straight into the meeting with Dr **I**. She was a duty doctor – I questioned her about her experience, but she did not tell me that she was a trainee. What we as a family witnessed when this assessment was carried out by Dr **I** was shocking and horrifying. It put me in an almost state of panic.

208. I consider that the entire assessment process was defective from start to finish. Darian said to her in that meeting that when he was on leave on this day, he was looking for trees to hang himself on. I asked him why he did that, and he said he wanted to hang himself. Dr **I** then said something like, *"What we will do is, if we can promise a cig break, you will not escape will you? Okay? We will give*

you 5 minutes or 10 minutes and you will not escape. You are okay, yes?" Darian's response was, *"Err, yeah, okay."*

209. Dr I was basically giving him the answers in his capacity assessment. It was as though she was putting words in his mouth. I could see that Darian did not understand the information that was relevant to the decision about his capacity, and it looked to me that he was unable to retain the information. We complained to Dr I and raised several objections to the way she was approaching Darian and asking questions, which she was essentially telling him how to answer. The doctor ignored and failed to realise that we knew Darian better than her, as she had never even met Darian before, and she went out of her way to negate our concerns during that meeting.

210. Dr I did not even test Darian for drugs but told us that his problem was drug induced. We asked her to section him, but she refused and told us that it was not for her to do, but that decision would have to be referred to someone higher up than her.

211. On 21 June 2020 at 19:18, I emailed Dr F and Dr Karale, setting out my concerns about Darian's treatment and I requested updates about Darian: *'Can I please be advised on how Darian has been getting on today, has his moods improve or the same or got worse, it is vital I feel that we observe his moods carefully, I am getting very concerned that as time is going by he is reaching new lows. Prevention is required immediately and his comfort blanket to be returned back to him immediately before it's too late. … I was told duty doctor would ring me no duty doctor rang. I am now left at the mercy of the hospital to hope and pray that they have the matter under control and all process are in place to cover all eventualities in place regarding Darian. Given what has happened today can you please allocate further resources at weekend to avoid a reputation of today which has led to a news blackout regarding my son.'* [**Kobad Bankwala e-mail to Dr Karale and Dr F].**

212. At 20:57 on the same day, I wrote to Dr H to obtain the reasons for the decision to keep Darian off section, and I also questioned her about what I understood where her refusals to receive Darian from Southern Hill back in April 2020: *'I would like you to provide me with extended reasons on your decision to get Darian of section 3. … Can you please tell me why you actively took steps with bed management to block his move to the Rochford hospital on several occasion given that you were made fully aware and provided you with extended reasons as to why it was vital for Darian to be at Rochford hospital. Despite this you made every effort to block this move. The first approach to bed management was made on the 20th of April please find enclosed attachment.'* **[Kobad Bankwala e-mail to Dr G].**

213. I note that on 21 June 2020, according to the Root Cause Analysis produced after Darian's death, that Cedar Ward *'staff declined Mr B's request to go out on day leave, due to issues the day prior, and Mr B subsequently threatened to abscond. Mr B's observations were increased to Level 2 (intermittent checks) and he was offered but declined PRN medication.'* **[RCA EPUT].** I note that

EPUT's records provide that on 21 June 2020, Darian was to be *'nursed on Level 2 observations in communal area and Level 1 in bed area'.* **[Form 4.1, 21 June 2020].**

214. On 22 June 2020, Dr H is said to have *'… enquired about whether [Darian] feels depressed as he reported this to his parents however it has not been observed by staff on the ward. He again remained quiet and did not answer.'* **[Form 16.10-00-CP produced on 07 July 2020].**

215. On 22 June 2020, it is also recorded that Darian *'became lively and asked to go out to have a cigarette',* and Dr H explained to him *'that he can do this only if he promises that he does not go to the railway station anymore, she informed him that the met police will charge him the next time he causes trouble there'.* **[Form 16.10-00-CP produced on 07 July 2020]**

216. I understand that during this interaction, Dr H 's noted clinical impression and diagnosis of Darian was: *'Mental and behavioural disorder due to multiple illicit substance misuse, mixed personality disorder, ASD traits (he is still under assessment) … There is an ongoing risk of him presenting at the railway station and threatening to harm himself or kill himself … these appear to be parasuicidal acts, he has always sought help and wants to be stopped from doing it as he does not want to die.'* **[EPUT Bundle 1, p. 42].** I will later address her unfounded allegations about Darian's drug use and her theory that he was '*parasuicidal*'.

217. On 22 June 2020, as noted by the Root Cause Analysis, Darian *'was deemed fit for discharge to the community'* by EPUT. I understand that on the same day, the BTP's Vulnerability Unit reviewed the incident on 20 June 2020 and graded his risk as *'HIGH'* due to his comments wishing to hang himself. **[BTP Fatality Review, 12 April 2021].**

218. The Root Cause Analysis notes that Darian's care co-ordinator, [I/S], *'explained that assessments of [Darian's] functional skills indicated that he could not live independently without significant support and that a Decision Support Tool was needed and to refer to Social Care for placement in intensive supported living.'* **[RCA EPUT].** It was also noted that Heidi and I, and Darian, *'were unwilling to accept him returning home and his needs were such that the council would not agree to house him in temporary accommodation'* **[RCA EPUT].**

219. Care coordinator 's statement for Darian's inquest notes, with reference to events on 22 June 2020: *'I had telephone contact with the ward Consultant Psychiatrist,* Dr H *on 22nd June 2020 regarding future care planning of Darian. I made clear that he had needs under Section 117 MHA and did not want to return home and that his parents did not feel that they could meet his needs at home. I also made clear that with these needs, a discharge directly to the council requesting emergency accommodation due to homelessness would not be supported by the council as Darian was identified as having difficulties living independently. I explained the process of applying for funding for this and the need for a Decision Support Tool and updated paperwork in relation to this.* Dr H *and myself*

agreed to follow this process to secure funding for 24 hour supported accommodation. A further ward review on 1st July 2020 reiterated the same issues about accommodation.' **[Care coordinator statement, page 4].**

220. On 23 June 2020 at 11:37, I received an e-mail from assistant *'Further to your email below, Dr H has advised that the decision to take DB off of sec 3 was made under the least restrictive option principle according to Mental Health Act Code of practice; patients who want to be in hospital should be treated informally. Dr H is not involved in bed funding. Rochford beds are funded by South Essex CCG and hence are normally only accessible for local patients.'* **[assistant e-mail to Kobad Bankwala].**

221. I received an e-mail from Dr Karale on the same day at 12:08: '*Many thanks for writing to me about your concerns regarding Chris Nota's care and the care of your son Darian. You have raised concerns about the Rochford Hospital (I presume Cedar Ward) and misuse of process, particularly in relation to law (presumably Mental Health Act and Mental Capacity Act). I note your concerns regarding the care given to another patient but unfortunately due to patient confidentiality I cannot provide you with additional information. However, the Trust takes concerns over patient safety very seriously. I have shared your concerns about Darren with the [I/S], Director of Operations He and I have called for an urgent meeting with those involved in the care of your son to ensure that your son is receiving appropriate care and treatment.'* **[Dr Karale e-mail to Kobad Bankwala].**

222. On 23 June 2020 at 12:13, I e-mailed assistant *'[I]t was requested that doctor (sic) provide extended reasons for her decision. All we have received is two-and-a-half-line response clearly that is not the extended reasons which I asked for. Could you please provide further and better particulars in relation to what was requested in my previous email? The matter with regard to bed management is as follows, when the request was put in by me giving extended reasons as to why DB needs to be in Rochford, bed management responded that it was not down to them to allocate the bed this was the decision of doctor I in Rochford and at present Dr H was not allowing this. In order for Darian to be given a bed we were informed that the steps we need to take should be put to Dr H and I and in accordance with that advice we took the appropriate steps.'* **[Kobad Bankwala e-mail to assistant].**

223. At 12:28 on the same day, I received a response from assistant, noting: *'Dr H has advised that you will receive answers to your questions in due course in the response to your complaint.'* **[assistant e-mail to Kobad Bankwala].**

224. At 14:11, assistant sent me a further e-mail, noting: *'Once a formal complaints process has been opened your questions will be dealt with through this pathway. For all urgent clinical issues you should contact the ward directly.'* **[assistant e-mail to Kobad Bankwala].**

225. I sent assistant a further e-mail at 14:28 on 23 June 2020: *'Once a formal complaints process has been opened your questions will be dealt with through this pathway. This would explain why you were so eager for me to formerly raise the complaint and were quite persistent that I take this step. I should have known better and not fallen for it. Had I not listened to you then you would have been forced to provide the answers. Really speaking in order to get quick results its best not to file a complaint otherwise it goes in to the long grass. That is why at first, I left it as informal request for information until you persuaded me to raise the complaint. How do you respond to that. You state For all urgent clinical issues, you should contact the ward directly. Please provide contact details and names and e mail information.'* **[Kobad Bankwala email to assistant].**

226. On the same day at 21:14, I raised concerns with Dr Karale in respect of the need for Darian to receive social care and the need to have joint communication between services so that he would not be homeless and without a proper care package upon discharge:

> *'In order for Darian to receive the appropriate care and treatment you need to allocate NHS resources and assets which means Darian needs to have the appropriate housing which is not just temporary for the time being it needs to be in line with his mental illness. Darian has told social services of his requirements; however, I can see that the social services are struggling as Darian was made homeless by Doctor* **H** *(sic)and not enough time was given for social services to find him the correct type of housing. Therefore, I suggest both NHS and the social services put their heads together and make a joint effort to put right the current circumstances my son is in. Two heads are better than one so I would like both NHS and Social services to come up with some bold and innovative solutions which is acceptable to Darian. I understand what Darian wants and his needs are, Social services understand what Darian wants and what his needs are, it's about time NHS took the same view and be on the same page and do not just leave it to social services to find a solution. … His care after being release (sic) from hospital would not be easy and the recovery would be very long and maybe never recover fully for a very long period of time and therefore the appropriate kind of housing needs to be provided for this long-term recovery. Doctor* **H** *(sic) with one swoop has demolished this and left him home less and vulnerable to predators. If you do not act properly in relation to his needs and care he will simply end up back in hospital. So, I urge you to go the extra mile, work closely with Social services, give them the help they need in terms of resources, any assets you may have make them available and add to any funding to whatever is in place in order to put right the current situation.'* **[Kobad Bankwala email to Dr Karale].**

227. I understand that EPUT's records from 23 June 2020 outline the support the Darian should receive if discharged into the community without support:

> '*It has been established that Darian is difficult to engage in his care and treatment. … Darian would benefit from being supported to access the community daily for 2 hours at a time to be*

able to develop some structure to his day, explore his interests and develop these. Darian to be supported to access meaningful activities and develop structure to his day that will promote healthy routine and the building of key social skills that he is lacking. Support Darian to develop supportive social relationships to reduce levels of isolation. … Darian has minimal awareness of his risks, and appears to require support from others to develop and sustain supportive relationships in the community. Darian also appears to display complex behaviours that may be linked to autistic traits, however due to non-engagement, Darian won't fully participate in psychological testing. Darian's limited levels of motivation also impact his ability to keep himself safe and recognise dangers' **[Care Act Review, Care Coordinator].**

228. On 24 June 2020, Dr F provided his formal report following his assessment of Darian in line with the request for a second opinion. He noted:

> *'I was asked by Dr H and Dr Karale to assess Darian Bankwala for a second opinion. My remit is to give an opinion on differential diagnosis and his management on the ward. … Opinion & Recommendations: 1. … I recommend that another attempt is made at undertaking a psychometric assessment whilst he is on Cedar Ward to determine his true IQ. 2. … would recommend that another attempt is made at carrying out [an Autism Diagnostic Assessment] on Cedar Ward in the hope that he may engage… 3. He does not currently present with any symptoms and signs of psychosis and depression. It is possible that the symptoms he presented with at that time he was admitted to Southern Hill Hospital in February resolved with treatment with anti-psychotic and anti-depressant medications… 4. I agree with Dr H 's decision to discharge him from Section 3 and continue the plans for discharge started at Finchingfield Ward as there had been no incidents at that point and he did not present with any obvious psychotic and depressive symptoms. … The decision to manage him as a voluntary patient should however be kept under review depending on his presentation and risks. 5. As the doctor/patient relationship between Dr H , the patient and his family appears to have irretrievably broken down, I suggest that consideration is given for Darian's care to be transferred to another Responsible Clinician at Basildon Hospital if Darian is agreeable to this. If not he can remain under Dr H as Responsible Clinician, but his ongoing reviews on the wards to be done by Dr H 's Specialist Trainee under the supervision of Dr H .'* **[Report, Dr F , Consultant Psychiatrist in Intellectual Disability Psychiatry].**

229. I felt that this assessment outcome was wrong. We had plenty of discussions with Dr F . Together we had agreed a process for his assessment. This would be for him to review all of Darian's medical records, read all our complaints to EPUT, then interview Darian, and then finally consult with Heidi and myself. He did not follow the process that we agreed together.

230. Dr F assessed Darian on 18 June 2020 – how could he have assessed that Darian had capacity, when Darian absconded on 15 June 2020 with the BWV of the police officer clearly showing him in an extremely vulnerable mental state? Darian still had clear symptoms. Instead, I consider that here there was foul play in the process that Dr F pursued. I think that there was a marker on the system, placed there by Dr H – that Darian was just *'parasuicidal'*, and this influenced other doctors. I found that there was such a marker in the records during the investigation phase for the Root Cause Analysis. I understand that *'parasuicidal'* meant that Darian talked of suicide but he did not act on it – an "all talk no action" situation. I consider that the doctors, including Dr F, would not go behind Dr H 's marker.

231. On 24 June 2020, Dr Karale received the complaint that I had made on 18 June 2020 about [I/S] Dr H as he noted in his statement for Darian's inquest: *'… my office was forwarded a complaint by [REDACTED] (dated 18 June 2020) against Dr H (complaint no. 28482) in relation to care and treatment of Darian … I advised Dr N, Deputy Medical Director to investigate the concerns expressed by [REDACTED] on 24 June 2020'* **[Dr Karale statement, §§ 6 - 7].**

232. On 26 June 2020, EPUT noted again the risks that Darian would face in the community, and the support needed on discharge: *'[Darian] if living alone in the community would benefit from support if in supportive housing as he shows poor independent living skills. [Darian] has poor social skills and could be at risk of being exploited. [Darian] has expressed an urge to hurt other people therefore he could be a risk to others or become vulnerable if attacked himself. Community mental health care co-ordinator to engage with monitoring mental health and to be actively supporting social care support to implement care plans to reduce/minimise behaviours.'* **[RISK document, Care Coordinator].**

233. On 26 June 2020, I understand the EPUT's records note that Darian expressed to staff that he wanted to end his life, but the staff member still told him that he could leave hospital if he wanted to, while noting that he should stay there until he secured supported accommodation and could then be discharged safely: *'I was informed by the security nurse that he said he just wants to end it all and she is worried therefore she did not allow him to go out. … He asked if he has still the option to self discharge and I explained that he is informal, he has continued to be stable in his mental state and there is a plan to discharge him to supported accommodation however if he wishes to he can self discharge against medical advice earlier. I explained that his parents have been particularly concerned and it would better if he could wait until we have secured supported accommodation for him so that he can be discharged safely. Plan: continue informal stay, awaiting for supported accommodation'* **[Form 16.1.00-CP, Dr O].**

234. On 30 June 2020, the risk plan for Darian stated that Darian would need daily support when he was to be discharged to the community: *'He will require daily support to meet his needs when leaving hospital and application to social care panel has been made due to this. Darian will require support*

and monitoring in the community by the Community Mental Health Team to ensure that his needs are met and his mental health is monitored and to understand the nature and degree of his mental health difficulties. Darian will have contact details of crisis team in the locality area once this has been ascertained.' **[Risk Assessment, Care Coordinator].** Darian was discharged without this daily support or a social care package – he never got either thing.

Discharge planning meeting on 1 July 2020

235. EPUT's notes from 1 July 2020 show that they regarded that Darian still needed hospitalisation because he was not well: '*Risk: Non compliance with medication. Self Neglect (poor diet and fluid intake, poor personal hygiene. Substance misuse. Violence and aggression. Vulnerability … views: .. Darian understands that he requires hospital admission as he is unwell. Plan: Short Term – For [Darian] to comply with his medication and treatment plan. For Darian to engage with OT whilst on the ward. Long Term: For Darian to be discharged safely to the community with support from the community mental health services.'* **[Care Plan Summary, 1 July 2020].**

236. On the same day, on 1 July 2020, a discharge planning meeting also took place. This was attended by *'Dr* **H** *(Consultant Psychiatrist),* **[I/S]** *(Ward Manager),* **[I/S]** *Nurse – Cedar),* **[I/S]** *(Locum Psychologist).* **[I/S]** *(Assistance Psychologist),* **[I/S]** *(Discharge coordinator),* **[I/S]** *(RWB),* **[I/S]** *(social worker),* **Care Coordinator** *(Care Co),* **assistant** *, PA to .* **Dr H** *(for minutes)'* **[Meeting Minutes, 1 July 2020].**

237. The notes from this meeting state that the working diagnosis for Darian at this point was *'Mental and Behavioural Disorder due to Substance Abuse/?Drug induced* psychosis' **[Meeting Minutes, 1 July 2020].**

238. The notes go on to show that the clinicians in that meeting commented that: Darian *'[b]ehaves as though he would like to stay in the system. Tries to deal drugs on the ward and has said that he can provide them to staff and patients. Being monitored – found with 3 lighters on him. Challenging behaviour but not mental illness … Is manipulative and a risk to other vulnerable people. Does not act like a victim. … Mother is highly anxious. Children always go to father and get what they ask for. Now not getting his own way all the time … As he has social care needs. Housing will not accept him. Going before Panel on Friday 3/7 for social care. As he preys on females, he should go to all male accommodation. Does not engage in any therapeutic groups. Does not benefit by being on the ward. Risk of accidental self-harm. Has never tried to harm himself whilst on the ward. Considered antisocial behaviour if he goes to the train station'* **[Meeting Minutes, 1 July 2020].**

239. In reference to the clinicians suggesting his attendances at the train station were incidents of antisocial behaviour (rather than as mental health and self-harm risks) and Darian earlier being told not to cause any trouble, as demonstrating the malicious attitude that staff had towards him – as you

will see below in more detail, the coroner at Darian's inquest also found there was a degree of malice in respect of some of the clinician's narratives about Darian. In respect of Dr H mentioning that Darian would be fined if he went to the train station, Dr H 's evidence on this point at Darian's inquest, based on my legal team's notes of her evidence, was that there was an *"agreement with the railway station for repeat offenders. They will send a letter to us asking if can bill … Want to use as a deterrent… [authorised this] once, one girl got £50 bill and she never did it again."*

240. It is important to say that the clinicians' comments about Darian in the discharge planning meeting can only be termed as lies. Dr H wanted Darian to be punished for attending the train station, she questioned unjustly whether he should be on a mixed ward, I believe she got the ward staff to say dreadful things about Darian, she told him to *"go and live [his] drug addict life"*, and even in her statement for his inquest she noted that she *'got the impression that he considered the hospital more like a base in the Southend area to socialise with friends than a therapeutic place.'* **[Dr H statement, p. 4/16].**

241. To deal with the unfounded allegations against Darian in turn, there was no evidence that Darian was taking illicit drugs when he was at Rochford (or even when he was at Southern Hill or the Linden Centre). When he was younger, he succumbed to peer pressure and did some, but this was not often. To the contrary, the evidence from EPUT's own records show that he was never seen bringing drugs into the ward. On 22 June 2020, it was reported that *'he has shown pictures to nurses, about drugs and cookies with drugs. However he has not been seen as bringing any drugs on the ward as far as we are aware.'* **[Progress Notes, Dr P].**

242. At Darian's inquest, Dr H gave live evidence and, based on HJA typed notes of her evidence, she said she *"… made it clear that there is no evidence"* of him taking drugs. The evidence of [I/S] RMN at Darian's inquest, based on my legal team's notes of his evidence, was that there were *"no incidents when he was on drugs, no evidence of him being involved in any crimes."*

243. I consider that the clinicians were fixated on this theory that his mental health issues were drug-induced. In fact, at some point before Darian was discharged, Dr H said that Darian could go and stay on the beach with his *"druggy friends"*. But Darian was too scared to take drugs. He was too scared to even take medication. And even if any patient at Cedar Ward was taking illicit drugs – that would show that the ward's security was not effective, and that the individuals were suffering from an addiction illness.

244. Regarding the allegations the clinicians made about Darian preying on women, this was unfounded. There was an alleged incident on 27 June 2020 when a female patient – one of Darian's friends at Cedar Ward – was reported to have fed him while he had his hands under his trousers **[DATIX, 1 March 2021].** EPUT's DATIX of this event was 'updated' on 1 March 2021 and it is unclear when it was first produced. It notes that *'staff asked [him] to take him (sic) hand out from his trousers and*

asked patient 1 to not feed him, they both complied with what was being asked' **[DATIX, 1 March 2021].** I note that young men sometimes do walk around or sit with their hands in their trousers, almost as a fashion statement.

245. At the inquest into Darian's death, even the coroner found that there *"was a degree of malice"* on the part of the clinicians who alleged that Darian preyed on females, based on my legal teams notes of the hearing:

> *"Perhaps the most striking and unfair designation was the phrase that 'as he preys on females, he should go to all-male accommodation'. It was so out of keeping with any of the evidence I have seen and heard that it does indicate to me a degree of malice on the part of those in discussion. The explanation that he 'preys on females' – finding its way into the formal medical records approved, as Dr* **H** *indicated that she would likely have approved – is fallacious. The only basis for it is a single incident of Darian sat with his hands down the front of his jogging bottoms as being fed Chinese food by an older female co-patient who had her own vulnerabilities. No suggestion that the attentions was anything other than a mutually supported friendship of some kind, perhaps subsequently borne out by the fact that when discharged, it was her address that Darian relocated to. For understandable reasons, Dr* **H** *did not feel able to give further details about that patient. But that was the sum total of the basis upon which it was suggested that Darian 'preys on females and should go to all-male accommodation."*

246. The coroner also noted that, *"[t]he impression is of a ward united in finding Darian to be something of an irritant."*

247. On being told that Darian was being discussed for discharge, I was arguing with Dr **F**, pleading for EPUT to just pause their decision as I needed to go and research if there was a way that I could act to stop it. I knew at the time that you could challenge a decision to detain, but I did not know if there was a route to do it the other way – to challenge a decision to discharge. I wanted time to research this point and see if I could seek an injunction. I think this scared the team at EPUT and instead they decided to speed the discharge process up. If I had known that there was a process through which this decision could have been challenged, I would have jumped on it. This is especially so given that Darian did not have the support that EPUT regarded he needed with his accommodation and social care. I remember that there was also another patient, who was around 60 years-old, who was due to be discharged but her property was not yet ready and so they kept her in and did not discharge her. She was allowed to stay pending her accommodation being sourced, but Darian, as would be the case, was not.

Discharge planning meeting on 3 July 2020

248. The Root Cause Analysis following Darian's death notes that on 3 July 2020, there was a CPA meeting at EPUT where it was noted that Darian had at some point that day disclosed that he wanted to die, but that the clinicians regarded this as an attempt to try to override the decision to discharge him: the *'ward team agreed [Darian] could stay on the ward until 7th July if he agreed to a care plan regarding engaging with OT and psychology on the ward and not to engage in inappropriate behaviour. Discharge from inpatient services was planned for 7th July at 10:00am. … He disclosed to staff "I want to die, I don't want to be here" and said he intended to stop eating, or hang himself, or "that train he had tried previously to go in front of". He denied any immediate plans to harm himself. … The hypothesis formed was of [Darian] wanting the psychologist to override the discharge planning from the CPA meeting that day.'* **[RCA EPUT].**

249. I understand that EPUT's medical records contain an entry that speaks to Darian's disclosure about wanting to die in more detail, showing that Darian even set out the ways in which this could be achieved. It is noted on 3 July 2020 at 13:50 that: *'In a psychology session, [I/S] the locum clinical psychologist notes] Darian then said "I want to die" "don't want to be here" - however he refused to elaborate why … Darian then said that he would do this [hunger strike / self starving] in coming away from the ward – would be trying to hang himself instead, or trying to do a "backwards backflip" in his room, that train he had previously to go in front of'* **[Form 4.1.00-CP, 3 July 2020].**

250. I think that it suited EPUT to say this. I consider that EPUT's agenda, to which it was working, was to release him from hospital either by hook or by crook.

251. In respect of the CPA meeting on 3 July 2020, the coroner's findings at Darian's inquest on 1 April 2022, based on my legal team's notes from the date, were that:

> *"As confirmed by* nurse practitioner *as she spoke to RCA report, there was a breakdown in communication as to what the plan going forward was. On the one hand, [W]ard were agreed that discharge was planned for Tuesday 7th July. The implication was that the meeting documented on 3rd July could have concluded with discharge on that day. What was set out was an extension of period from 3rd to 7th on what was understood by the family and by Jenny Tanner to be predicated on the basis of two contingent aspects: 1) that Darian did not misbehave (if so, zero tolerance letter), and 2) engaged with OT/psych assessment. Neither of those contingent triggers were occasioned. He did engage that afternoon for some half an hour. … And there was no further untoward behaviour, as confirmed by Dr* H *herself. In those circumstances, the expectation of both parents and* care coordinator *that there wouldn't be a discharge, contrary to the position of the ward that there was a plan that there would be discharge but it would be earlier if he did not engage or if he misbehaved. The practicalities of*

organising an earlier discharge were not entirely explored [and] 7th remained the date of discharge. Panel application [was] fixed for 8th. Does not appear to have featured."

252. On this day, I had sent e-mails to Dr H 's office for her attention. At 12:57pm, I wrote: *'You pressed him on something he could not quite communicate back with you and put up a reasonable defence because he lacks capacity so what happens, he tells you to shut up. … Capacity is often misused and is not often fully understood and can be mi applied in order to promote a different outcome. It is this capacity argument which has been applied in correctly which has got him to where he is today.'* **[Kobad Bankwala e-mail to Dr H].**

253. At 15:21pm, I wrote again to her office following our CPA meeting, asking her to provide a report and evidence for the allegations made about Darian's behaviour, which, as I set out in my e-mail, we were never informed of previously: '*You pressed him on something he could not quite communicate back with you and put up a reasonable defence because he lacks capacity so what happens, he tells you to shut up. … Capacity is often misused and is not often fully understood and can be mi applied in order to promote a different outcome. It is this capacity argument which has been applied in correctly which has got him to where he is today.'* **[Kobad Bankwala e-mail to Dr H].**

254. On 4 July 2020, at 10:25am, I wrote an e-mail to Dr H stating: '*what has happened here is that short cuts have been taken in the time table in relation to his discharge and often it is the case that short cuts run in to problems further down the line and often fail*' **[Kobad Bankwala e-mail to Dr H].**

Darian's discharge on 7 July 2020

Local authorities – Essex County Council and Maldon District Council

255. Darian was discharged from hospital against our concerns as a family, care coordinator 's concerns, and contrary to EPUT's earlier assessment that supported accommodation was needed for a safe discharge. For example, 26 June 2020, Dr P said that the plan for Darian was to *'continue informal stay, awaiting for supported accommodation (sic)'* **[Progress Notes, Dr O 26 June 2020].** I consider that funding considerations played a significant part in this decision, and that EPUT were passing Darian onto the social services to deal with.

256. Before I set out what happened on the day that Darian was discharged, I want to take this opportunity to set out what I understand to be the sequence of events regarding EPUT and BTP's Care Act referrals to the local authorities. This is important to understand the unsafe discharge by EPUT, but also it is in answer to Questions 101 – 102 and 105 – 107 of your Rule 9 Request.

257. As a family, we were once again fearful that when Darian was to be discharged from hospital, his aftercare service would not be properly put in place and neglect would once again creep in, sooner or later causing him to have another breakdown and ending him back up in hospital. I was afraid that this process would just keep repeating itself until the day that would come where he would end his life or someone else's life.

258. On 8 June 2020, I understand that EPUT's records note that care coordinator agreed that Heidi and I *'would benefit from supporting the Care Act assessment for Darian's review and that they required carers assessments separately to allow them to express their views confidentially and explore understanding of Dairan's situation.'* **[Care Activity, care coordinator].**

259. I also understand from the inquest statement of BTP officer, in respect of BTP's involvement in Darian's assessments and incidents, that: '*[o]n three occasions BTP's Vulnerability Unit made Care Act referrals to Essex County Council outlining the incidents involving Darian and their concerns. These referrals were made following the incidents on the 11th June 2020, 15th June 2020 and 20th June 2020. The referral made following the incident on the 11th June 2020 was made on the 12th June 2020 and a copy of the report submitted to the Vulnerability Unit from the officer and a covering email was included. The referral following the incident on the 15th June 2020 was made on the 17th June 2020, and again a copy of the report submitted to the Vulnerability Unit from the officer and a covering email was included. The referral following the incident on the 20th June 2020 was made on the 24th June 2020 and an e mail containing details of this incident was included with risks identified as physical and/or mental health, emotional wellbeing and the need for care and support.'* **[BTP officer statement].**

260. To this, I do not understand why Maldon District Council did not receive the referrals instead of Essex County Council, as they would have been the ones responsible for sourcing accommodation for Darian.

261. I understand that the Root Cause Analysis states that Heidi and I both had separate carers assessments on 25 June 2020, but I do not remember this.

262. I understand that on 2 July 2020, care coordinator *completed an EPUT/ECC Social Care Funding Form Referral Form for supported living. [EPUT, Medical Records 539], and it was noted his case was due to go to panel for housing on 3rd July for social care.'* **[RCA EPUT].**

263. Darian never received any social care support under the Care Act and he did not get supported accommodation from when he was discharged on 7 July 2020 until the day he died on 27 December 2020. I just remember that the local authority, Maldon District Council, would tell us that they had nowhere for Darian to go. I offered to help them look for accommodation by providing my secretarial services, but they declined offer to help. There was a lot of back and forth with them. We were told by

the local authorities that Darian was better off at home with us and we disputed this. I do not remember anyone from the council sitting down with us to discuss these issues. **Care coordinator**, even though she had raised concerns about Darian's discharge, also told Heidi that Darian was better off with us.

Discharge paperwork on 7 July 2020

264. The medical records from the day that Darian was discharged note:

a. *'… Darian stated that he would not take his medication if discharged and Dr* **Q** *explained that he would deteriorate mentally if he does not take his medication. … Darian also expressed concerns about his living arrangements and stated that he would be homeless. … It was also explained that his parents were happy to have him back previously and his case would be going to panel tomorrow. … No current acute mental illness. Darian has capacity to make discussions and understand reason for discharge. No evidence of thought, plan or intent to harm self or others. No evidence of violence and aggression.'* **[Form 4.1-00-CP, 7 July 2020**

b. A document called 'Form 17.6' was completed by a doctor called Dr **R** - I do not think this doctor was involved in Darian's treatment – which was signed on 19 August 2020. It reads: *'… With regards to the suicidal thought Darian said that he did not want to die and wants to be prevented from doing it. However he added that he wanted to remain in the hospital as he was worried about the fact that he will harm himself impulsively. … No evidence of mental health problems on the day of discharge. … Medication on discharge: Olanzapine 5mg ON; Mirtazapine 45mg ON … Good prognosis if compliant with medication and engages well with community services. Good prognosis also dependant on good familial support. Identify early deterioration and seek help from GP / A+E / CMHT. CPA: 24 hour courtesy call. 7 day follow up by CCO* **[I/S]** *Community consultant follow up in 4 – 6 weeks post discharge. Crisis team number provided. Discharged to home address. … Advice: Stay away from drugs and alcohol. Take medication regularly'* **[Discharge Summary, 19 August 2020, Dr R (GPST2 to [I/S] Dr H].**

c. *'… Darian's disappointment was evidence he said he had been 'set up' and he wanted to stay in hospital to avoid being 'sectioned'. He was reminded that he had managed to stay informally on the ward, take leaves of the ward and keep himself said. He could continue to do that in the community, he said he was not sure.'* **[Form 16.10-00-CP, Dr Q].**

265. **Dr H** 's statement for Darian's inquest also said that at '*the time of his discharge, his initial depressive and psychotic symptoms had been in remission for 3 months.'* **[Dr H statement].**

266. Again, I go back to the BWV of the police officer from 15 June 2020, which was from just shy of one month before his discharge from Rochford. One review of this footage would show the opposite to

what Dr H claims: it very clearly shows Darian in a psychotic state. His presentation here is like that which he had when he was first admitted to Southern Hill which caused him to be sectioned.

267. There was no family input into the final discharge plan. This discharge was an ambush for us as a family. I do not remember there being a home risk assessment (given the previous incidents which EPUT knew about where Darian was threatening us, behaving violently at home, and even said he wanted to see me hang).

Discharge process on 7 July 2020

268. On the morning of 7 July 2020, a nurse called Heidi and I to inform us that Darian was going to be discharged.

269. At 10:59am, I e-mailed Dr H, impressing on her that Darian was at risk to himself and others: *'Nurse S has just rung to day and said that Darian is going to be discharged today. This is to inform you that he can not come home as he is a danger to him self and other (sic). You are requested to look at the social services report.'* **[Kobad Bankwala e-mail to Dr H].**

270. I rang care coordinator, Darian's CPN and care coordinator, who informed me that she was not aware of Darian's discharge and that she was not ready for this. CC told me she would ring Rochford to find out what was happening, as she wanted to have the decision overturned. I understand that she was in communication with the clinical staff at Rochford.

271 Care coordinator's inquest statement notes: **'***I do clearly remember parents ringing me, whilst on his way to Rochford Hospital telling me that Darian was being discharged back to their home. In circumstances where a Decision Support Tool has been carried out with a plan for funding for post-discharge support and where the patient is willing to remain on the ward, I would have anticipated Darian to remain on the ward. In the instance of a decision being made to discharge Darian, I would have expected another CPA to have been called prior to discharge. My understanding at that time, was that the plan remained for an appropriate placement to be found for Darian, via the Section 117 Funding Panel; that he would remain on the ward until such a time as it had already been identified. … I therefore raised a Datix to the Trust regarding an unsafe discharge to highlight that a decision to discharge Darian had been made without consideration to his social circumstances.'* **[Care coordinator statement].**

272. In the meantime, I quickly made my way to the hospital with Heidi to make sure that Darian would not leave. When Darian was released from Rochford, to our horror, we were informed that Darian had been provided with a travel warrant to get on the train on his own despite his repeated incidents at the train station during his admission, which led to BTP raising referrals and grading his risks. As soon

as we heard this, we made sure that the hospital withdrew the travel warrant. This is evidenced in Form 4.1 where it states, *'Ward to give Darian a travel warrant'* **[Form 4.1-00-CP, 7 July 2020].**

273. When I got to the hospital, I found that there was a taxi outside. I understand that Rochford had recalled the travel warrant and got a taxi instead. They were putting Darian's belongings in the taxi. I did not allow Darian to get into the taxi. I think Heidi took Darian away from the scene. I sat there waiting for the Rochford staff to come back out of the ward to speak to me, and then the police turned up. The hospital had called the police on me because I sat outside the hospital waiting to see the consultant in order to reverse the decision to discharge Darian. They had called the police to remove me.

274. Rather than engaging with me as a very distressed and concerned parent who just wanted to speak to the consultant psychiatrist treating his vulnerable son, EPUT called the police on me and I consider that this was an unnecessary and unjustified escalation. My concerns were confirmed, so when the police heard my side of the story, they did not remove me. This day was described as an *"unsatisfactory state of affairs*" by the coroner in his findings at Darian's inquest, according to the notes of my legal representatives from the day. This, taken with the earlier incident on 15 June 2020 when **Dr H** 's demeanour towards me was intimating, indicates to me that she had animosity towards me because I actively questioned and her accountable for her and her team's clinical decisions. There was clearly a pattern of adversarial and punitive conduct which was directed at me. This severely undermined the relationship of trust and effective partnership between us and EPUT at a time when Darian faced acute risks.

275. Against all the previous assessments, requests for social care and supported accommodation, Darian was discharged by **Dr H** . I think it is important now to mention an individual called **[I/S]** . I think he was Darian's care coordinator when he was at Southern Hill or the Linden Centre. He told me that he did not know why he was appointed as Darian's then care coordinator. He said he was an *"older guy"* and Darian would need a younger person and preferably a female – that is how, as I understand it, **care coordinator** came to take over the role as Darian's care coordinator. I remember **him** telling me that the care for patients like Darian was just too expensive – he said it would cost around £500,000. He said that patients go in and they go out - some survive and some do not. He said that that is the way it goes and that there are casualties in the system, but no one cares. He said that no one is keeping an eye on things. I consider the significance of this individual goes to a broader point about EPUT's general culture, and its funding procedures.

276. In her evidence to the inquest, **Dr H** claimed that Darian had *"declined supported accommodation."* I consider that this was another lie on **Dr H** 's part. I recall when she would say that Darian said something, Heidi and I would question Darian about the thing he was supposed to have said, and he denied it and said that **Dr H** was lying.

277. We raised complaints about Dr H. One was about her treatment of Darian and the other about her treatment of us, his parents. I think that both of the complaints were quashed, but after Darian's death, we made further complaints, including to the General Medical Council, which remain on-going, as noted below.

278. I also note that when Darian was at Rochford, there was another patient there who was in her 60's. She liked Darian. She once asked me to *"do something about"* Dr H. There was also another patient there who said that Dr H was horrible and had told her that if she (the patient) were ever to have a child, that Dr H would personally make sure that the baby was taken away from her. Dr H was nasty to Darian and I would describe her as a bully towards him. This opinion was shared by an ex-EPUT worker that I spoke to after Darian's death, whose name I cannot remember, who said that Dr H was a power hungry bully, including towards other staff. I consistently asked EPUT for confirmation of whether and how many complaints Dr H had received at EPUT but I did not receive this information – I believe this information is crucial for your investigation into EPUT's healthcare provision.

279. I also want to refer you to the incidents I have mentioned above, when we as a family had previously asked that if Darian were to be sent home to us, that we would need a detailed plan and support – which we did not eventually get.

Darian's homelessness

280. When Darian was released, he did not stay at home with us until towards the end of July 2020. EPUT's records note that this was on 28 July 2020 **[Care Activity,** care coordinator **30 July 2020].** Darian did not want to stay at the family home in Maldon. I recall that Maldon District Council said that he was not their responsibility, I asked them to coordinate Darian's housing situation. I have since raised complaints with Maldon District Council in respect of these matters, and they have since said that they will not speak directly to me without a solicitor.

281. From when Darian was discharged, he was effectively discharged into homelessness. I understand that Root Cause Analysis says that on 9 July 2020, *'staff discussed supportive housing and an assessment was planned for the subsequent week'* **[RCA EPUT].** Darian never received supportive housing.

282. On 13 July 2020, it was recorded by EPUT: '*Please see enclosed a copy of the carer's assessment undertaken through EPUT mental health services as the above person has been identified as a carer for a client accessing our services. … We wanted to inform you that there are ongoing stressors in regard to the caring role and home situation and these are having an impact on the [REDACTED] overall wellbeing.'* [I/S] **letter, Family Group Conference Team Manager].** As above, I do not remember having any carers assessment or discussions.

Care and treatment in the community

283. I cannot remember how long it took for care coordinator to contact Heidi or myself. I think this was around three to five days after Darian's discharge. I doubt it was with immediate effect on 7 July 2020.

284. Care coordinator's statement for Darian's inquest notes that on 16 July 2020, Darian was not taking his medications: '*They corroborated that he was not taking medication consistently. Due to Darian not answering phone calls, and not responding to text messages, the initial assessment at Florence House, Southend, was cancelled.'* **[Care coordinator statement].** Because of Darian's non-compliance with his medication, which CC was aware of, I told her that on one occasion that we had to sneak medication into Darian's food as he would not take it. She said that this was illegal and to not do it.

285. Matters did not improve with Darian. Heidi and I tried to get him back into hospital. Police were called out to our home twice. But EPUT would not section Darian again. This is even despite EPUT knowing that Darian was not taking his medication – as set out in Dr J's statement for Darian's inquest: *'… I was informed that although, Darian was discharged … being on a combination of an antipsychotic medication Olanzapine 5mg a day and an antidepressant Mirtazapine 45mg a day, in the post discharge meeting with his care coordinator, Darian informed* care coordinator *that he had not been taking the medication as prescribed. I was also informed that Darian was not keen to take any antipsychotic medication.'* **[Dr J statement].**

286. Dr J went on to say in their statement that: *'… I felt that an antipsychotic medication was not immediately indicated. Besides it was decided that based on future assessments, if indicated, it can be initiated at a later period. I suggested that, if Darian experiences low mood and anxiety, if he wishes to, an alternative antidepressant called Escitalopram can be considered.'* **[Dr J statement]'.** This doctor was **'***aware about the risks of health and safety involving Darian's care [and] was aware that Darian has (sic) expressed suicidal thoughts to kill himself by jumping in front of a train [… and] considered that Darian had a chronic self-harm risk which could be exacerbated by the stressful life situations. Hence it was decided that the FEP Team would be monitoring the risks'* **[Dr J statement].**

287. EPUT's records from 21 July 2020 state: *'1. Response from caring role [REDACTED] doesn't feel able to address this until Darian's situation improves. To re assess when [REDACTED] requests a review of carer needs. 2. Support with how family manage stress situations … 5. Risk management plan should her son return home with them after discharge. To inform care coordinator. … [REDACTED] isn't suitable to continue with any family group conferencing at [t]his point as Darian was not wish to engage with family based interventions'* **[EPUT Letter to care coordinator].**

288. On 23 July 2020, it was noted that care coordinator *'had a face to face meeting'* with Darian when *'[a]ccommodation options were discussed'* but it is claimed that Darian *'wanted to move somewhere that would be permanent and fit his fixed ides about layout, or felt he would not be able to settle'* and that he *'declined to sign the letter facilitating [care coordinator] to engage with the council on his behalf.'* **[RCA EPUT].** I do not consider that any reasonable adjustments were made for any of these meetings in light of his mental health needs. I do not consider as his father that Darian had mental capacity, and so do not consider that Darian would have understood the questions that were put to him (just as before when we attended a Teams meeting with Darian and the clinicians and we had to told the clinicians that Darian was not understanding the questions they were asking him).

289. On 23 July 2020, I made a further complaint about Dr H, and this included a complaint about Dr Karale too. I raised concerns about Darian's discharge, the lack of aftercare, Dr H professional conduct, and Dr Karale's lack of engagement in responding to our concerns about Darian's treatment. Sometime after this phone call, our complaints were closed. I do not understand why they were closed. These would later be re-opened when EPUT was doing an investigation report following Darian's death.

290. Around 28 to 30 July 2020, when Darian had returned home, it is noted in the Root Cause Analysis that Heidi and I had informed care coordinator that Darian was being *'volatile again, not eating [and] pulling [his] hair out again.'* **[RCA EPUT].** The same document notes that care coordinator left *'a prescription for seven days' supply for Escitalopram 5mg increasing to 10mg for a further seven days along with Diazepam 2mg TDS.'*

291. Darian continued to deteriorate. He would lie in his bed all the time. He stopped eating. He did nothing. I saw my 5 ft. 11" son become thinner until he weighed just over 7.5 stones. Yet, care coordinator did not do anything effective to help and did not think this was *"sectionable behaviour"*. I remember that she saw him twice in Southend. But Darian stopped taking his medication as he said it made him feel worse and he could not think. At some point his medication was changed to anti-depressants, but Darian would not take these. He would stay in bed all the time. Care coordinator told us not to pester him and to let him get out when he was ready.

292. I understand that EPUT's records for 6 August 2020 state: '*Attended s117 panel, agreed funding for 50/50 health social care, but continue to explore what this could look like for Darian. Plan to meet with* [I/S]*, Consultant Social Worker tomorrow to discuss case.'* **[Funded Social Care document, care coordinator].**

293. Around August or September, Darian had another melt down. We had to ring a number which was given to us by care coordinator. We were given a number which I think relates to some sort of NHS mental health line. When we rang the number for help, we were told that Darian was not on their system, so they could not provide help. They asked to speak with Darian, but Darian was not in any

mood to speak with them. We informed care coordinator of the incident and told her what had happened and told her that we were told that Darian was not on their system. At the time of reporting Care coordinator told she would have taken steps to makes sure that next time we had to ring the service, Darian would be on the system. I feel it is important to show that Darian needed to be sectioned once again, and numerous opportunities and signs were ignored over and over again to re-section Darian, and yet again this instance was another missed opportunity to get him the help he needed.

294. On 7 September 2020, it is noted that: '*Contact was initiated by Darian's mother on 7th September 2020 expressing further decline with Darian exhibiting a more haphazard approach to eating and now consistently not taking any medication. He was having periods of appearing "fixated and obsessing" about his thoughts, but at other times was reported to be quite happy in himself.'* **[care coordinator statement].**

295. It is noted that on the same day, there was a discussion between Care coordinator's and a redacted name (I assume this was Heidi Bankwala) about *'formal detention in hospital as an option. [redacted] will see if Darian is amenable to a conversation [around] non-concordance and hospital admission, as a way to promote engagement with myself and medication.* **[Care Activity, care coordinator 7 September 2020].**

296. On 18 September 2020, there was a visit to our home by care coordinator and a psychiatrist. Care coordinator sent a text to Heidi, stating: '*… we discussed planning on visiting this afternoon at 3.30pm. … the consultant wants to come with me today which is not a bad idea … shows we mean business?!'* **[care coordinator text to Heidi Bankwala].**

297. Care coordinator's inquest statement provides more details about this: on 18 September 2020, '*jointly visited Darian with Dr* [I/S]*, Consultant Psychiatrist with the C-FEP team and Darian's treating Consultant in the community. During this assessment, Darian engaged for over an hour with us both, engaged in a formal mental state assessment and he did not present with psychotic phenomena. … Psychiatrist diagnosed from this joint assessment was that despite no formal diagnosis of autism, Darian was presenting with Autistic traits and unspecified anxiety symptoms. He continued to decline any offer of further assessments from our team or other teams.'* **[care coordinator statement].**

298. The psychiatrist who attended, Dr J, said in their inquest statement that: '*During the assessment, careful consideration was given whether Darian was experiencing any Psychotic symptoms. In the assessment, there was no behavioural abnormality suggestive of an underlying disorganized mind. The assessment lasted over an hour, and during this period there was no distraction observed which may indicate a perceptual abnormality, e.g. voice hearing experience. Although mildly tangential at times, there was no clear abnormality in his thinking patterns. From the clinical assessment I had with Darian, it was clear that there was no evidence of a psychotic illness.'* **[Dr J statement].**

299. On 24 September 2020, Heidi sent a text to care coordinator explaining Darian's further deterioration: '*He explained that this is incredibly difficult right now too and that when he doesn't shower, its not because he's last, it's became he cannot simply make these decisions. Even washing his hair can cause a dilemma. I did say he could speak to you but unfortunately he relates you to someone who deals with mental health issues and he doesn't believe he has any of those! I found that Darian doesn't want to hear why he maybe (sic) getting these functional issues but just wants someone to listen, any wrong comment can lead him to feeling that the 'puzzle is being messed around'. I have reassured Darian that we re (sic) all here for him and will help him … I don't really know how to deal with the situation, any advice would be welcome.'* **[Heidi Bankwala text to care coordinator].**

300. Care coordinator 's response to this on 24 September 2020 was to text back with: '*Can I ring you later tomorrow afternoon for a catch up. Sounds positive that he opened up to you about this.'* **[care coordinator text to Heidi Bankwala].**

301. EPUT's records from this day set out his presentation of not eating, talking or being engaged and notes that he was sectioned with the same behaviours six months prior: '*Has been taking his medication, sleeping longer in bed, not eating. … he is having trouble making decisions in getting out of bed. He has been presenting with low motivation, he is functioning less and less … Not eating, talking or engaged … He was previously sectioned for 6month in February because he wouldn't eating, talk and this made him violent. His social worker advised him to call 111 to (sic) because of this behaviour. He has not been taking his medication because he feels it made him worse.'* **[111 Crisis Call Form, 24 September 2020].**

302. On 25 September 2020, as Darian's mental health condition was getting worse, and he was getting worse at an alarming rate, his health had deteriorated to such an extent that once again Darian started to get very abusive and violent towards Heidi. He closed the bedroom door where Heidi was and started to throw things at her and generally getting physically violent towards her. The only way she could escape from his clutches was to push him hard to one side and leave the bedroom. On hearing this, our other son CSB got so worried and concern that he called the police. The police came to investigate the matter and visited our house on two separate occasions.

303. Care coordinator was told about this because Heidi sent her a text: '*We had some problems with Darian yesterday. It escalated over me trying to get him out of bed! He's started to lay in bed until 6pm. In the end I suggested we call someone so that he can get help. This unfortunately went down lie a led balloon and Darian then got angry and started trying to attack me when I was alone. He blocked my door so I couldn't get out of the room and started punching me and throwing things at me. Police were called by my fourth son when he got home and they've made a note of it as being an altercation due to the fact that I didn't want to press charges and Darian has mental health issues. … Obviously this is something that can't carry on and although Darian calmed down, he still doesn't want*

to take meds, therapy or counselling or live elsewhere (in the choices given) which leaves us back at square one and all very vulnerable. … In my mind the word 'consent' seems to be the thing that is blocking Darian from getting help and ultimately putting him in danger and the people that he lives with in danger too.' **[Heidi Bankwala text to care coordinator].**

304. All I recall care coordinator responding was that Darian should be told that he could behave like that, and he knew right from wrong.

305. On 3 November 2020, I understand that following the home assessment, a report was produced to state: *'Diagnosis: Autism Spectrum Disorder, No clinical evidence of psychosis or mood disorder, Unspecified anxiety symptoms… Current medication: Escitalopram 10mg once a day … Medication: Nil of note. Darian is currently not taking any psychotropic medication. … Risks identified: Risk of self neglect – chronic. Risk of self harm – low, can escalate [in] response to adverse life events. Risk of harm to others – chronic / moderate. … Risk management plan: (1) To continue to monitor (2) To refer to the Autism Anglia for further support'* **[Care Review / Care Plan, Dr J].** I remember after this meeting, I was told that the team could not further discuss this with me as they did not have Darian's consent to do so – which I consider was untrue.

306. On 5 November 2020, Heidi sent a text to care coordinator raising that Darian was not getting better: *'I'm wondering if you're able to prescribe Darian some more diazepam, he's finished the ones you gave him. I think he may need a higher dosage as he still gets very stressed and doesn't eat a lot. I've noticed recently that he's lost more weight, this is despite taking escitalopram fairly regularly.'* **[Heidi Bankwala text to care coordinator].**

307. On 9 November 2020, Heidi sent a text to care coordinator again with the same concerns, this time making it clear that he was self-harming and intervention was needed: *'Darian seems to be deteriorating again. He rarely gets out of bed, yesterday he spent only one hour out of his bed and the same today. He's awake more of the night padding up and down outside my bedroom door. He's only showered once since you were last here so as you can imagine he smells. He appears to be more agitated and has tried to attack me twice recently and he's not eating, existing on a glass of coke a day some days and that's literally it. Now refraining from social media, games etc and not taking any meds. At one point he was taking meds, I'd say for about 8 weeks but he did not appear to be a great deal better. He's self harming again and is like a bomb ready to blow. I really feel something should be done as I'm very worried about darians (sic) behaviour and ultimately Darian. As a secondary issue he is threatening to kill me again, slit my throat in my sleep, watch me hang, mess with my sleeping tablets etc., he's lunging at me again and threatening to kill the cat again! … I think we need some intervention … help!'* **[Heidi Bankwala text to care coordinator].**

308. In her statement for Darian's inquest, care coordinator noted that on 9 November 2020: *'[a]fter discussion with Dr [I/S] in light of the mood deterioration and limited reported response by parents to*

an antidepressant, we decided to see if Darian would engage with Aripiprazole (an antipsychotic), which also has some mood stabilising impact to it to see if this would have an positive impact on his mental health.' **[care coordinator statement].**

309. On the same day, *'[c]onsidering Darian's refusal to engage with the mental health services,* **[I/S] care coordinator** *decided to visit Darian weekly.'* **[Dr J statement].**

310. On 10 November 2020, **care coordinator** sent a text to Heidi stating, *'Ok, no worries will attempt to address these issues with darian (sic), including that disengagement from me will be a trigger for concern and possibly hospital. At least the antidepressant was tried and we know it didn't make any difference. Can you keep a behaviour log and food/fluid diary as if situation continues to decline it would be helpful if the only route left is hospital admission under section.'* **[care coordinator text to Heidi Bankwala].**

311. On 13 November 2020, I recall Heidi and I had a meeting with **care coordinator** where we reported to her that Darian was eating less, not engaging, was hostile, and made threats to slit our throats in our sleep.

312. I note that Dr **J** s statement for Darian's inquest notes that **care coordinator** *'visited Darian on 13th November 2020 at home, where he declined to get out of bed. Although agreeable to see his care coordinator Darian avoided to see his care coordinator on 2 subsequent Fridays, i.e. 20 and 27 November 2020.'* **[Dr J statement]**.

313. On 4 December 2020, Heidi messaged **care coordinator** to say that there appeared to be some improvement, but that Darian had taken *'no medication at all now for approx. 5 weeks. … And any advice on how to enhance these improvements would be great.'* **[Heidi Bankwala text to care coordinator [I/S]].** **Care coordinator** arranged to have a discussion with Darian in early January 2020 as she would be on leave for Christmas – with no alternative care coordinator put in place and with no one to turn to.

314. Overall, when Darian returned home he started to slip into his old ways. He was getting violent again, not taking his medication (which EPUT were aware of and themselves noted), and despite our very serious concerns as a family which we raised with EPUT and despite our assertions that he should be re-admitted to hospital, Darian remained in the community in his vulnerable state.

Darian's death on 27 December 2020

315. A week before Christmas, Darian started becoming more agitated and aggressive, especially towards my wife. This was not the first time Darian would get angry with us. He would do this almost on a monthly basis and for no specific reason. Frustratingly however, no one would help us even

though we made EPUT and care coordinator aware of this situation. We felt like we did not receive any support and more importantly, Darian did not get the help he needed despite the warning signs.

316. Around that period before Christmas, Darian started pacing and becoming more agitated. He would be in his own world and did not seem able to make decisions. Once, I saw him open the fridge to get something, but he could not make up his mind, and would close it. Looking back, it seemed like the same kind of confusion and deterioration I saw before he went to hospital in February 2020 and was sectioned.

317. I noticed that Darian would change between two phases of either becoming very child-like and attached to Heidi and I and not wanting to leave us, and another phase of complete indifference and distance. When he was in that phase of distance, I can only describe it as if he was possessed by his illness.

318. I thought Christmas Day was a nice day as we all had Christmas lunch together, and Darian seemed to be less agitated as he was distracted by his other brothers and in particular talking to my other son CMB and his girlfriend. Darian became agitated when Heidi's parents called to speak with us all. He went into the garden and would not return to the house until they were off the phone. The call triggered him, and he got upset. We did not see too much of Darian on Boxing Day, and he did not want to go shopping.

319. On the 27 December 2020, Darian had woken up early. When Heidi had gone down, she saw him fully dressed and lying in the lounge. I first saw Darian after coming out of the shower. Darian came into our bedroom looking very agitated. He said he was looking for his shoes. I offered to help him find them, but he refused. He left our bedroom in the same agitated state as he had entered, and a short while later I heard him leave the house.

320. Heidi told me about a comment he made about not wanting *"to be buried in Southminster*", which was really worrying. Our instincts were to follow him, but we did not think that would be appropriate, and we thought that to do so would more than likely antagonise him and make his condition worse. We were beside ourselves with worry, but we simply did not know what to do for the best.

321. As above, care coordinator was on annual leave, and we did not have an alternative care coordinator to contact. We agonised over whether to call the police or an ambulance. In the end, we concluded that neither was likely to provide the urgent assistance and support that we needed (they never really did before). We decided that we would try and find Darian ourselves.

322. Heidi was able to track Darian down via Snapchat to Southminster up until approximately 13:30pm, but then he disappeared. Heidi wanted to call him but I told her not to as I was worried that this might trigger him into doing something rash. At around 14:00pm, Heidi and I decided to drive to all the local

train stations to find Darian, but we could not. We arrived at Wickford Station at 16:00pm but could not see him. We were growing increasingly frantic and although we each kept trying to reassure each other, we were both dreading the worst.

323. Eventually, Heidi and I decided that it might be best to go home in the hope that Darian might just turn up there. We stopped at Burnham Station briefly and could not see him there. Heidi spotted the "Bethlehem star" - something that Darian had really wanted to see and so she took a photograph of it for him. We were both desperately clinging on to the hope that Darian would be found alive.

324. We got home around 17:30pm. Heidi could not contain herself any longer and tried calling Darian but there was no reply. Even though deep down we knew it was unlikely, we told ourselves that he might have met a friend in Wickford. We were desperately hoping that Darian was alright and that nothing bad had happened. We agreed that if he was not back by the last train at around 22:30pm or 23:00pm, then we would call the police.

325. Darian did not return home by then. So we called the police. We did not know how long they would be and so we were unable to just sit and wait. We decided to go to Wickford Station to look for Darian again. We had not got far when my other son CSB called and told us to come back home immediately as the police had arrived.

326. The police asked us lots of questions about Darian and his movements on that day. I was feeling numb with anxiety at that time. I recall Heidi kept saying he must be dead, and the police were trying to reassure her. I found the conversation very traumatic to listen to. The police eventually left at around 01:00am. I do not recall exactly what they said when they left. I think they told us to get some sleep.

327. Although Heidi and I did go and lie down, sleep was out of the question for us. I kept thinking of what Darian must be going through, how desperate he must be feeling, and imagining him going onto a railway track and getting hit by a train.

328. When the police came back at 04:00am and knocked on the door, I felt as though the ground had shifted beneath me. I was immobilised by shock. I could sense what they had come to tell us and I did not want to hear it. Both Heidi and I struggled with the idea of going to answer the door. Eventually, we did, because we had to. The police then told us what we both already knew – we had been repeatedly thinking of Darian getting hit by a train from the moment he had left the house, and the police just confirmed those thoughts as reality. I would welcome the Inquiry to seek any body-worn footage of the attending police offices from their two attendances in the hours leading to Darian's death, to obtain evidence of the human impact, trauma and devastation caused by EPUT's systemic failures.

329. It turns out that Darian was seen by train driver standing on the track. He was struck by a train travelling at approximately 75mph **[Inquest Bundle 1, p. 14, [I/S] statement].**

330. The driver of the train gave evidence for Darian's inquest: *'I am sure, I had my brake on, as I was approaching … I had to stop at, but as my train proceeded suddenly a person was picked up in the four foot in my head lights. The four foot is the space between a set of running rails. I estimate that this person was about 5 meters in front of my train. I was on an approach to a station so slowing but at that time estimate my speed was between 65 or 70 mph. I recall my train hitting this person and believe I then applied the emergency break to stop the train.*' **[Inquest Bundle 1 p. 15, train driver].**

331. I understand that the ambulance service's records note that the 999 call was made at 16:43:55 **[EEAS Records 2],** which was picked up at 16:44:19 **[EEAS Records 2],** and the first paramedic arrived on the scene at 16:54:49 but Darian was deceased on arrival, with this being formally confirmed at 17:17 **[EEAS Records 2].**

332. I have so many questions about how Darian died – which I think is relevant to the safety of Darian's discharge and how EPUT was information sharing with BTP about Darian's risks. Related to this question, I note that Dr H evidence at Darian's inquest was, according to my legal team's notes from the day: *"multi-agencies are involved [when] e.g. where child protection services are involved or where the police are involved … our team was confident that these [3 BTP incidents, talk of supported accommodation or going home, concerns around learning disability and autistic traits] incidents were directly linked to the section being lifted. Confident it was a temporary thing that would not continue … chronic suicide risk but not acute. Didn't think it was justified at this stage to involve police. … they were three incidents within 10 days, we would only get MAT involved if it was an extended period that we believed would continue."*

333. How is it that Darian was able to access the train station tracks? Why were there no alerts? With all of the previous incidents that took place in the previous few months with Darian attending the stations, and with BTP's own records following those incidents – how did Darian still manage to end his life there? Where were the staff? Did no one see him? Why was the area not secured? Was there adequate lighting? Why was there no CCTV footage at all from that station on that day? I consider that the CCTV at the station on this day was switched off. At the inquest when asked about this by my counsel, the BTP witness said they did not have any information on this.

334. Anglian Railways were made aware by us before Darian was sectioned that he was suffering from mental health problems as he was receiving fines thick and fast for not paying for a ticket, we paid fines with explanations - some fines went through and some fines were quashed. Even the conductors knew of Darian because they were the ones who would have to ask him for a ticket. I seem to remember some time back saying to some of the ticket issuing staff that if they found that Darian was unable to pay for the ticket due to his mental illness, I gave them my mobile number so

that I could immediately pay for the ticket. I think from memory there were some issues with this method and was told there were difficulties in implementing such a process. I remember a time when Darian was in hospital, and I was travelling on the train one of the [I/S] came up to me and said that he had not seen Darian for some time on the train and asked about his wellbeing, and I had to inform him that Darian had been sectioned.

335. On 27 December 2020, I think that the station had inadequate staff cover and there was only one person there at the ticket office. It is worth noting that very quickly, if not the next day after Darian's death, Anglian Railways immediately increased the staffing levels. My other son AB decided to go to the station to try and see for himself what could have happened as he was walking up and down the two platforms trying to work out for himself what could have happened to Darian. AB was approached and intercepted by a station staff member at the platform and was questioned about his presence and the activity. AB gave his explanation. I think if there was adequate cover on 27 December 2020, then Darian would have been intercepted and questioned in the same way, and his behaviour and activity would have been reported to the BTP, which would have triggered alarm bells. The people who were clinically responsible for his safety, EPUT, would have been informed and then perhaps at that point EPUT would have had no alternative but to section him as they were not listening to our concerns and worries and were trying to downplay all the incidents. These incidents included the time when the police had to be called just a few months before Darian's death in September, and on another occasion when a telephone call was made to 101 for assistance from the psychiatric team, which was never forthcoming.

336. It is also particularly concerning that BTP's Post Incident Site Report from 22 January 2021 noted: *'Related incidents: A check of BTP's crime and intelligence system indicates that in the 12 months prior to this incident there was one incident of trespass and one person detained under Mental Health legislation at the station. Additionally, one person came to notice on several occasions and has been under the management of local mental health services.'* **[BTP, Post Incident Site Report].**

337. The Post Incident Site Report also noted: *'The railway on the Western approach to Wickford Station has various types of fencing forming the boundary, all of which are in relatively good condition. The fence near the open parkland is chainlink whilst that in the car park at the station is a combination of palisade, weldmesh and chainlink.* [I/S] [I/S] [I/S] [I/S] [I/S] *. The station ticket office is staffed 7 days a week* [I/S] [I/S] *There is a CCTV system with a monitor within the staff are of the booking office which is visible to the staff,* [I/S] *. … Due to the lack of information with regards how the deceased accessed the track, there are no specific and justifiable recommendations to make in this case.'* **[BTP, Post Incident Site Report].**

338. As outlined in detail above, Darian went to the rail station before this when he was a hospital patient a few times. Heidi and I warned EPUT that if Darian was taken off section, this would happen. They did not take this seriously. Even at his discharge they gave him a train ticket to use, before we stopped this.

339. On 22 June 2020, it was noted that: *'There is an ongoing risk of him presenting at the railway station and threatening to harm himself or kill himself … these appear to be parasuicidal acts, he has always sought help and wants to be stopped from doing it as he does not want to die.'* **[Form 16.10-00-CP, Dr Q 7 July 2020].** Just six months after that assessment was made, Darian died in exactly the same way they knew he was at risk of dying – he was not parasuicidal in the end, but as we always said, he was actively suicidal.

340. I blame the death of my son Darian on the decision made by **Dr H** to discharge him from hospital back to the community, when there was no supported accommodation available for him despite there having been a plan to send him to a half-way house for a period of time, and when he was a known risk to himself and to us. I consider that **Dr H** blew these plans into the water, despite the warning and DATIX raised by her EPUT colleague, **care coordinator**. This harmed Darian's recovery plan.

341. I genuinely believe that if EPUT had taken a different route and approach, in particular the one that Heidi and I were prompting (not to discharge him unsafely and when he was ready for discharge then to ensure he had a half-way house with support upon discharge) then my son would still be alive today. He would have gone on to do wonderful things in life.

After Darian's death

Post-mortem

342. I understand that Darian's autopsy, which was carried out on 6 January 2021 and reported on 8 January 2021, noted that his cause of death was *'1a) Multiple Severe Injuries 1b) Struck by moving locomotive (train) 1c) II) Mental Health Disorder'* **[Autopsy Report, Dr [I/S] (Consultant Histopathologist)].** I also note that the toxicology report dated 20 January 2021 said: *'No compounds were detected within the scope of this screen. In particular, there is no evidence for escitalopram use in the hours prior to death'* **[Forensic Toxicology Report, [I/S] (Principal Clinical Scientist)].**

Police complaint

343. When Darian died, I informed the BTP that I wanted to report **Dr H** for manslaughter. The Detective Sergeant, **[I/S]** of the BTP, told me after listening to my complaint that I should

make sure what I said to her was mentioned to the coroner. [I/S] [I/S]. I was told that once the coroner saw the information, they would then ask BTP to formally investigate the matter for manslaughter, at which point the police would commence the process. Due to one reason or another this did not happen, which meant that there was a loss of opportunity to proceed with a manslaughter investigation at the time.

344. On 13 February 2021, I emailed [I/S] (a Fatality Investigator at the BTP): *'As you know we have a meeting on Wednesday 17th February at 11:30 at your Southend BTP Office. At this meeting I would like to make it official and wish to formaly (sic) inform the British Transport police about a criminal act perpetrated against my son Darian by EPUT and in particular naming* Dr H *from Rochford hospital. … would also like to add that I also name* Dr H *'s Boss. Who is Dr Milind Karale who is Consultant Psychiatrist who is Executive Medical Director at EPUT and also name the Director of Mental Health and the Executive Director of Operations at EPUT for the death of my son Darian Bankwala. I repeatedly told the EPUT directors that I was concerned the way* [I/S] Dr H *was behaving and that I was extremely worried that Darian would end up taking his own life. On multiple occasions I pleaded with* Dr H *and the EPUT Directors not to release him from the hospital as it was too soon. I state that Doctor* H *acted with malice and was the in sighter and chief of the criminal acts and that her leaders at EPUT failed to act decisively and further more after just one email from Doctor Karale. all further emails from me to Doctor were ignore and no replies were sent.'* **[Kobad Bankwala e-mail to fatality investigator**

345. On 15 February 2021 fatality Investigator replied to me: *'I have spoken today with Essex Coroner's office to discuss Darian's case and to ensure they are aware of the various issues being raised about EPUT/ Darian's care. They have confirmed to me that are aware of the issues being identified and have already requested information be provided to their office from the relevant agencies involved and also mentioned that EPUT are also conducting an internal review of Darian's case and will provide HM Coroner with the results of this. I believe the Coroner's office may have already informed you of this (so I do apologise if I am repeating information to you) but they also stated to me that they are planning to Pre Inquest Review Hearing, where I believe yourself (and any other member of Darian's family wishing to attend), representatives of EPUT and I will all be present with HM Coroner to discuss the various matters being raised. This Pre Inquest Review assists HM Coroner to determine what issues are being identified and what information they feel needs to be obtained and provided to them ready for Darian's inquest.'* **[** Fatality Investigator **e-mail to Kobad Bankwala].**

346. I do not think that a manslaughter investigation ever took place, and I want this pursued.

347. Care coordinator would be the Family Liaison Officer during EPUT's investigation into their care and treatment of Darian. I remember that Heidi and I raised concerns about this, given her role as Darian's care coordinator previously. I wanted someone else to be appointed to the FLO role, which was arranged for us.

348. EPUT produced a Root Cause Analysis following Darian's death.

349. I have a series of e-mails between myself and the investigation team, where I raised many concerns about the manner of their investigation. These are available for the Inquiry's review, and I will only set out some of those interactions in this statement.

350. On 18 January 2021, at 21:21pm, I e-mailed [I/S], who was the Head of Patient Safety Incident Management and Morality at EPUT: *'I would like to be part of the investigating team which you are embarking on. In our conversation we touched on the reasons as to why it would be reasonable and practical for me to be part of that team so that I may help and guide you in the area you need to look and consider … You have on the phone given me an assurance that you will not suddenly cut me out of the loop on the investigation in to my son's death and that you will work with me in all of this. Can I please have EPUT undertaking and assurance that they will work with me at all times and will not cut me out of the loop under any circumstances. I know you have given me a verbal assurance on this. It would give me peace of mind if I was also to receive a written undertaking and an assurance on this.'* **[Kobad Bankwala e-mail to [I/S]].**

351. On 24 February 2021, I e-mailed [I/S] with my concerns that EPUT were not complying with their duty of candour duties **[Kobad Bankala e-mail to Head of Patient Safety Incident Management and Mortality].**

352. On 25 February 2021, [I/S] e-mailed me stating: *'Whilst the investigators are of course employed by EPUT, they have been appointed as professionals who did not have any involvement in Darian's care and treatment and who do not work within the service that provided this care. This is to ensure that the investigation is objective and that staff involved in the investigation process feel confident in being open and honest; this is in line with the Serious Incident Framework's aim to promote a fair, open and just culture that looks at system learning to prevent incidents recurring.'* **[Head of Patient Safety Incident Management and Mortality email to Kobad Bankwala].**

353. On 27 April 2021 at 08:56am, I raised concerns about the independence of the report authors in an email to the investigation team: *'I am very concerned to see that the Authors (sic) work was reviewed by Dr Milind Karale – Executive Medical Director, Natalie Hammond – Executive Director of Nursing. I was given an assurance by the investigating team that they would be the owners of this report. I was*

concerned that there would be interference by Dr, Milind Executive medical director as I had made a complaint about him and that I also held him responsible for the death of my son. To Discover is that matters were reviewed by the persons I have accused of are taking part in reviewing your work. This is wholly in appropriate and is stomach churning. He had no business to review your work and for him to review your work is a conflict of interest. Whilst I have not had the opportunity to read the full report yet within the first few pages, I have already found errors.' **[Kobad Bankala e-mail to EPUT].**

354. I continued to provide my input, making corrections, disagreeing with their approach and findings, and raising that many of my other concerns – including those about **Dr H** – were not being addressed or investigated.

355. A Root Cause Analysis was completed on or around 22 June 2021, with the draft version dated 3 June 2021, with the investigation team being noted as **[I/S]** (Advanced Nurse Practitioner – 14 years as MHN) and Dr **[I/S]** (Consultant Forensic Psychiatrist). Despite Dr Karale being involved in the care and treatment of Darian (sourcing a second opinion, and responding to my complaints about his treatment), he was named on the RCA as one of the reviewers of the RCA; with Natalie Hammond, the Executive Director of Nursing at EPUT, being another.

356. I consider that the RCA was not fit for purpose. Many changes were made in the report, and in the end, I did not find it satisfactory and the team and I had to agree to disagree before the RCA was needed for the coroner's investigation.

357. In particular, there was a battle between **nurse practitioner** and myself. I considered that she was trying to bury the issues that I was raising with her about EPUT. I met **nurse practitioner** and **consultant FP** together. Afterwards, when I wanted further discussions with them, he ignored me. Darian's records were accessed only months after his death. I asked for these documents to be forensically reviewed. I spoke to Paul Scott about this and I was referred to someone called 'Denver'. I had a meeting with Denver in person when she herself told me that she was not a fan of Dr Karale and that I should not worry as he would not be involved any further.

358. The summary of RCA findings were, in summary: *'[1] formal risk assessments were not updated in accordance with EPUT policy across a range of clinical teams … [2] despite there being concerns around medication concordance regularly throughout Mr B's admission, there was no evidence of consideration being given to managing this during discharge planning, especially where non-concordance would not have led to assessment under the MHA … [3] Cedar Ward MDT minutes are visible within the clinical records which provides a good oversight of the patient and the plan. However, the minutes are made by a non-clinical member of staff which then resulted in inappropriate language being used in clinical records … [4] there was confusion between the team on Cedar Ward and CCO 2 around the discharge plan for Mr B, which led to a perception from community staff of it being an unsafe discharge. The potential for escalation of the issues were missed due to this confusion and a*

lack of awareness of EPUT Policy … [5] the 48 hour follow up call from Cedar Ward was not carried out and documented in accordance with policy … [6] MDT discussions within the First Episode in Psychosis Team were not documented on the clinical system and that notes made were repetitive and not always updated … [7] there were minor omissions in clinical notes made by CCO 2…' **[RCA EPUT].**

359. For all of the reasons outlined above, as set out in the various incidents and complaints I have detailed, I consider these findings to be incomplete, lacking, and wrong.

360. As noted above, the RCA referred to **Dr H**, noting that Darian was *'parasuicidal'*. I consider that this was a marker that she put on whatever systems they used – which essentially said that Darian would not have acted on any suicidal thoughts. And yet, Paul Scott would later come to say in a letter to the family that while the discharge from hospital was unsafe, it would not have altered the outcome. So, on the one hand, Paul Scott is saying Darian was always going to end his own life, whereas **Dr H**'s view was he was only parasuicidal and by definition therefore would not **[Paul Scott letter to Kobad and Heidi Bankwala, 14 November 2023].**

361. I made a complaint about Dr Karale again, and on 26 June 2021, I received an e-mail from the complaints team to note: *'The Medical Director, Dr Karale, has appointed Dr* **N**, *Deputy Medical Director, to investigate the concerns you have raised. Once the investigation is complete, we will respond to your concerns. We are in receipt of several emails you have sent in regard to this. I understand you have already been contacted by Dr Karale in regard to this.'* **[[I/S] (Complaints & PALs Manager) EPUT e-mail to Kobad Bankwala].**

362. On 30 June 2021, I received another e-mail from the same team, stating: *'We have been advised by the Patient Safety Incident Team of concerns that you have raised regarding Dr Karale, Dr* **H** *and your late son's care that require a formal complaints investigation as they do not fall within the scope of the Patient Incident Safety Investigation. I would like to convey my sincere condolences to you and your family at this very sad and difficult time.'* **[[I/S] (Complaints & PALs Manager) EPUT email to Kobad Bankwala]**.

363. On 9 July 2021, **[I/S]** the investigator and who was due to give evidence at the inquest, e-mailed me, stating: '*I wanted to provide you with an update in relation to the Serious Incident report. During a meeting with myself and* **[I/S]** *on 15th June, it was agreed that the concerns you raised about specific practitioners would be forwarded to the complaints department for their investigation. This information has been shared with EPUT's complaints department who are investigating separately.'* **[investigator e-mail to Kobad Bankwala].**

364. On 16 August 2021, I wanted further disclosure from EPUT in respect of incident that occurred on 9 February 2020 when Darian was discharged from hospital only to return within 24 hours, when nurses

then told Heidi and I that they had raised a complaint about the doctor who had discharged Darian. I e-mailed EPUT: *'Within 24 hours of arriving home, we had to bring Darian back to A&E, and we bumped in to you at the reception again, and you stated to me that you were sorry that this had happened, and we knew that he would return back to hospital and that you felt it was wrong that Darian was allowed to return back home and that you had filed an internal complaint about this matter. Darian was then had to remain outside in the car park where his two brothers and a security guard from the hospital (can you also thank him for helping us out as Darian was biting him) and to restrain Darian until the police were called, and he was then detained under section 136 of the mental health act and then was subsequently detained under section 2 of the mental health and then followed by section three under the mental health act. Can you please provide me with detail information of the internal complaint both of you made, and please inform me of the outcome of the internal complaint which both of you made.'* **[Kobad Bankwala e-mail to EPUT].** This information was not provided to us.

365. On 9 September 2021, Heidi and I met with CFP CFP agreed with us that Darian most likely had schizophrenia, acute OCD, psychosis and anxiety. He also agreed with us that whilst Darian was not on any medication or getting therapy his illness would have been deteriorating. I asked CFP if he knew what would have caused Darian to take his life. Heidi interjected with her explanation and CFP said he agreed with Heidi. Her explanation was that she felt Darian would have been overcome with OCD, possible psychosis and the fact that his mental process or thinking disorder was failing him and his only way out in his thought pattern was to take his life, that was probably what made sense to him at that time. Heidi said she thought Darian was completely consumed by his OCD and this was possibly why he did not even leave a note or switch his phone back on, on that day. We told CFP that everyone in the community could see how ill Darian was, and he should have been re-sectioned. We said we felt that we were not listened to.

366. I mentioned above at Paragraph 357 that I had noticed that Darian's medical records had shown some activity months after his death. I recall these were DATIX documents. I have referred to DATIX documents throughout this statement and have noted the unusual dates of the documents in brackets that I am aware of (there could be more) – for example, Paragraph 244 and Paragraph 128. During our above meeting with CFP I did ask whether it was possible for anyone to make entries on a DATIX system after someone's death. CFP replied that this would not normally be possible and that it would be a criminal offence to do that. I asked CFP to explain why the DATIX records appeared to show that someone had gone into Darian's record on certain dates, some months after his death – for reference, I showed him my handwritten notes of each of these documents being accessed on dates that were some three to four months after Darian's death. CFP did not address this further. I later raised this with [I/S] the PA to Paul Scott. She said she would look into this but I heard nothing further. I want to know why these documents were accessed, by whom, and whether there were any additions, deletions, or amendments; and whether this would be in line with

EPUT's policy or the law; and whether there were any other medical records that were amended, deleted, or added to in Darian's case after his death.

367. On 16 September 2021, I received an e-mail from EPUT's complaints team: *'I understand you were due to receive a response by 17 September 2021, unfortunately, the investigation into your concerns is taking a little longer than anticipated. Therefore I would like to request to extend beyond the agreed timescale, with a new date of 14 October 2021. I will ensure that you receive a further update if we encounter any further delays.'* **[[I/S] (Complaints Reporting Administrator) EPUT email to Kobad Bankwala].**

368. I had a few meetings with Paul Scott – I think our first contact was around September 2021. I said to him that the report was nonsense. I had argued with EPUT that he could not be the owner of the report because I had raised a complaint about him to EPUT when Darian was in hospital and therefore his position had been prejudiced and that he should go nowhere near the report, let alone have the final say over it and be its owner. At one stage, Paul Scott said that he would get someone else to look at the report independently. He said that the money to do so would come from Dr Karale's budget but that he would not be involved in the report. I understand that Paul Scott told Dr Karale not to get involved with the investigation. I consider that Dr Karale nevertheless interfered with the investigating team and had the final say over the report findings, hence he was named as a reviewer. I think that this was a deliberate cover up of the wrongdoings between **Dr H** and Dr Karale.

369. On 14 October 2021, I received another e-mail from the complaints team: *'we hope to be able to provide you with a response by 15 November 2021 covering the issues raised in both complaints.'* **[[I/S] (Complaints & PALs Manager) EPUT e-mail to Kobad Bankwala].**

370. On 16 November 2021, I received another e-mail from the complaints team*: 'we would hope to be able to provide you with a response by 30 December 2021'* **[[I/S] (Complaints & PALs Manager) EPUT e-mail to Kobad Bankwala].**

371. On 30 December 2021, I received another e-mail from the complaints team: '*I understand a response was due to be with you by today, and I am sorry we are unable to provide you with the response. I can confirm that the investigation into your concerns has concluded; however, all responses to complaints have to undergo a strict quality assurance process to ensure that the outcome of the investigation is accurate and comprehensive. As part of this process these are reviewed by senior and executive staff before undergoing final review by our Chief Executive. Your response is currently with the Investigator for their review. We can at any time be requested to gain further information or clarification to ensure that you receive a robust response and whilst this is not anticipated it can occur. In view of the above we would hope to be able to provide you with the response by 27 January 2022.'* **[[I/S], Complaints Reporting Administrator, EPUT, e-mail to Kobad Bankwala].**

372. On 28 February 2022, I received EPUT's letter of response to my complaints **[EPUT's letter of response to Kobad Bankwala].** I responded on the same day: *'I will be taking the matter further with EPUT as the information in this document in areas is factually in correct and simply misleading. The document is inaccurate, incomplete and calculated to mislead. Some of the complaints have not even been considered and have been left out.'* **[Kobad Bankwala e-mail to EPUT]**.

373. On 2 March 2022, I emailed EPUT's Paul Scott and his PA, setting out my concerns, which included:

> *'During my first team meeting with the investigating team. I asked the team as to whom they would report to, and I was told it was the medical Director.*
>
> *I informed them that this constitutes a conflict of interest and that the medical director should not have any involvement in supervising the team. I informed the team that I had made a complaint about the medical director and therefore his position had been prejudiced, and he should not be allowed to come anywhere near the investigation team and that the investigating should actually investigate the medical director. This was not done, and I say that constitutes a breach of policy and procedure.*
>
> *I was told that* Dr G *from the linden centre would not be providing a statement, and at first the investigating team said that they would expect this position. The reason given was that* Dr G *from the linden centre had retired, and therefore he was permitted, and it was excepted by the enquiry team that he will not be investigated nor will he provide a statement.*
>
> *… it was suggested … that RMN* [I/S] *Cedar Ward, Rochford Hospital would not provide the information. …After some further questioning … by me to the investigating team person it came to light that the investigating team had sent an email to RMN* [I/S] *Cedar Ward, Rochford Hospital as there was no response from the email, she communicated with RMN* [I/S] *Cedar Ward, Rochford Hospital line manager and that she was informed by the line manager that RMN* [I/S] *Cedar Ward, Rochford Hospital was un well. As far as the investigating team was concerned, that was the end of the matter and that avenue would not be perused. It turns out that RMN* [I/S] *Cedar Ward, Rochford Hospital had not seen the email and nor was he ever told what had happened and eventually when this information came to light RMN* [I/S] *Cedar Ward, Rochford Hospital had every intention to cooperate and provide a statement. It is clear to me that a member of the investigating team rather act in such a way that it could avoid getting this statement.*
>
> *… This investigation has been very badly been conducted, and some members have tried to prevent and limit the scope of the investigation by not allowing the various members to be*

interviewed and questioned and to keep them out of the investigation .Ultimately, I had to approach a higher Authority, and this Higher authority overturned the decision that the investigating team not to bring in members of the EPUT in the investigation.' **[Kobad Bankwala e-mail to Paul Scott and his PA].**

374. On 15 March 2022, I met with Paul Scott and EPUT's Operations Director. The meeting lasted around two hours. The agenda which I had put forward for the meeting was that EPUT had failed in their duty of care to Darian to make sure that Darian was kept safe. We discussed issues relating to Dr G 's (Linden Centre) and Dr H s (Rochford) conduct and behaviour and in particular that Dr H had put a *'parasuidical'* marker on Darian's medical records which prevented others from making the right decision to keep him safe which ultimately led to Darian's death. I said to him that I held Dr H responsible for Darian's death.

375. We further discussed matters in relation to the investigating team and what part Dr Karale had played in that. We further discussed the series of wrongdoings and that matters that had in my view been covered up. It was agreed that moving forward, these issues would be further investigated by Paul Scott. I was due to be invited to meet with him again and would be working very closely with him to get to the truth of what really happened to Darian and how this could be prevented from happening again.

376. Paul Scott asked Heidi and I what we wanted out of that process, and I explained that the truth needed to be told and that I expected EPUT to take action against Dr H and that I could not understand, given the gravity of our allegations whilst the investigation was taking place, how she had not been suspended from work.

<u>Darian's inquest</u>

377. The final hearing for Darian's inquest took place between 23 March 2022 and 1 April 2022 (with Pre-Inquest Review Hearings on 13 April 2021 and 30 June 2021).

378. I have set out some of the relevant evidence where relevant in my statement above, and take this opportunity to provide my thoughts on the inquest process, and the conclusion that was reached.

379. From my legal team's notes from 1 April 2022, I understand that the coroner gave a narrative conclusion, which said:

'*The deceased took his own life when he placed himself on railway lines on the approach to Wickford Railway Station. It is unclear how he accessed the train lines. The deceased had been provided with a range of differential diagnoses by five consultant psychiatrists in the ten months or so preceding his death, including over an extended period as an in-patient detained*

under section 3 of the Mental Health Act 1983. He had been admitted to three acute mental health wards, from his first admission in February 2020 through to his discharge on 7th July 2020 into the care of the community based First Episode of Psychosis Team. The most appropriate working diagnosis that emerged over this period included, but was not necessarily limited to, Autism Spectrum Disorder with mild learning difficulties in the context of Darian's borderline IQ. The combination of these aspects of Darian's neurological developmental disorder and consequent presentation meant that he was persistently unwilling and unable to engage in the formal psychological assessments which would likely have led to psychologically based treatments. Darian resisted such assessments (and thereby precluded the possibility of treatment) notwithstanding the very best efforts of his parents, over many years, to encourage him to engage. There was insufficient evidence to conclude, on the balance of probabilities, that the use of illicit drugs directly or significantly contributed to Darian's presentation over the last six months or so of his life or at the time of his death. Whilst the evidence establishes, on the balance of probabilities, that Darian took his own life by placing himself in the path of a train on 27th December 2020, in the context of his mental health presentation and his learning difficulties the evidence does not disclose, to the requisite standard of proof, his intention at the time that he took himself to the railway line.'

380. I consider that the inquest process was not thorough enough and that it did not cover or deal with all my concerns. I have already set out that the RCA report given to the coroner was defective. I feel that during the inquest process, the representative for EPUT should have been stopped at some point when asking questions of Heidi as the manner of it was inappropriate. The coroner must think very carefully when allowing others to questioning bereaved family. I broke down in court at one point, and I remember the coroner came up to me and told me to take it easy otherwise I would end up in hospital.

381. I cannot remember if a Prevention of Future Deaths report was made at Darian's inquest. In any case, I do not think that the PFD system is effective. All the coroner does is just set out their concerns. But whether any changes are made is not monitored. The reports are not followed up. They get buried. Why else are there still so many deaths after these reports?

Communications with EPUT after Darian's inquest in respect of my complaints

382. On 6 April 2022, I wrote to Paul Scott and Alex Green and set out my reasons for linking Darian's death to **Dr H**'s decision to discharge: *'My son was treated by EPUT. After release from hospital, his treatment by EPUT continued from our house. This was not supposed to happen it was agreed Darian would go to a half-way house when he left hospital for a period of time as it was not safe for him to return home.* **Dr H** *from the Rochford hospital in Essex in an act of Malice then went on to ambush us and blew such plans out of the water by taking such steps that its prejudiced Darian's recovery plan. It was further argued by us that he was not ready to be released*

from Hospital. At this stage, I do not want to drift in to chapter and verse of each and every daily issue that arose and the different various heads of complaints in this email in relation to the various wrong doings that occurred and started immediately from day one when he was admitted under the care of EPUT. The series of ongoing wrong doings continued throughout, which led to Darian's death.' **[Kobad Bankwala e-mail to Paul Scott and Alex Green of EPUT].**

383. I had another meeting with Paul Scott on 12 October 2022, after which he sent me an e-mail at 12:12pm, stating: *'Please find attached the report commissioned from* **the** *Medical Director at Cambridge and Peterborough Partnership NHS Trust. Please accept my apologies for the delay in sending to you. As I suggested I suspect there is nothing in the report that will satisfy you enough not to proceed with the next steps we agreed today: 1) Agree the key questions you would like an investigation to answer. We agreed that Denver will send you our first draft of this which has been extracted from your emails – we would welcome your reflection on these and suggested amendments. You will work with Denver to agree a timeframe. 2) We agreed that these questions will form the scope of the investigation. 3) We also agreed that the process of the investigation will be agreed between us. We discussed some options and that is something you can agree with Denver. Whilst we will endeavour to do this in parallel, the process will be partly determined by the nature of the questions agreed.'* **[Paul Scott email to Kobad Bankwala].**

384. On 19 June 2023 at 14:36, I sought clarification by e-mail from Denver Greenhalgh as to whether it would have been EPUT who would have made a request to the Care and Quality Commission for Darian's funding to the private hospital. I wanted to see that funding request and what was said in that request. I wanted to see the full report on his aftercare funding, which would have involved EPUT and the social services. I also wanted an update as to what investigations were being done to look into why Darian's medical records were accessed after his death [**Kobad Bankwala e-mail to Denver Greenhalgh]**. Denver Greenhalgh wrote back on the same day to say these would be looked into.

385. After Darian's inquest, I lodged a formal complaint with Paul Scott, identifying that the SI report sent to the coroner was materially inaccurate and that I considered that **Dr H** and Dr Karale had interfered with the process.

386. I consider that EPUT's senior management eventually gave in, and in 2024, a civil claim was settled with EPUT (no liability admitted).

<u>GMC and NMC complaints</u>

387. In 2024, I made complaints about the following individuals with the GMC.

a. Dr **G** (Linden Centre, EPUT)
b. **Dr H** (Rochford Hospital, EPUT)

c. Dr I (Rochford Hospital, EPUT)
d. Dr F (EPUT)
e. Dr Karale (EPUT)

388. I understand that my complaint to the GMC remains under investigation. I have also complained to the NMC about care coordinator and nurse practitioner; and to the CQC generally.

389. To avoid jeopardising these investigations, I have not set out any substantive details here about these investigations, but would be happy to do so on the Inquiry's request if permitted by GMC procedures, and I am happy to share all of my correspondence with the GMC regarding these complaints with the Inquiry if permitted.

My views and recommendations for change

390. I consider that the following changes are needed if the mental healthcare provision at EPUT and even nationally is to improve:

a. Education authorities must ensure children with special needs receive one-to-one support and guidance for integration into the community. Local authorities must provide carers or key workers to assist families in managing activities outside school. Education authorities have statutory duties to identify children in need and support them and their carers – and if this was done in Darian's case, in a way that was effective, meaningful and consistent, and in concert with CAHMS, I consider that the problems that followed could have been avoided.

b. Continuous mental health oversight must be provided from childhood through adulthood for those with known mental health or special needs vulnerabilities to prevent avoidable harm.

c. Mental health assessments must involve independent clinicians and families, with full written records, and process for assessing someone's capacity should have full integrity and not be manipulated.

d. Clinicians should not have unilateral authority to make life-altering decisions like de-sectioning someone; without informing families of what legal safeguards there are or how those decisions can be challenged.

e. High-risk hospital discharges or transfers must be reviewed through a formal multi-agency process including families, local authorities, and independent clinicians - particularly when families object or the patient has recently been sectioned.

f. Families raising warnings about the patient's risk to life or safety must have their concerns logged, investigated, and escalated. Families should never be dismissed or blamed for raising concerns.

g. Mental health Trusts must declare staffing levels and safety risks in real time. Concealing shortages or misrepresenting service capacity should be treated as organisational misconduct.

h. Staff working at other government departments that interact with mental health patients, such as the DWP, must raise safeguarding alerts when needed. Vulnerable individuals must never be coerced into work they are incapable of performing – and reasonable adjustments should be made to allow them to use the services effectively.

i. Medical records must be protected from retrospective alteration, particularly after a patient's death. Changing records posthumously should be pursued as a criminal offence, with strict safeguards implemented.

j. Mental healthcare funding decisions must be informed by those providing direct care. Individuals assessing funding must not act as loss adjusters reducing resources without expertise in mental health and knowledge of that particular patient.

k. Mental health trusts and clinicians must provide complete and truthful evidence to inquests, inquiries and other investigations or legal procedures. Misleading or incomplete disclosure should carry legal and regulatory consequences – this should be in practice, not just in theory.

l. Families must be treated as partners in healthcare. Trusts should provide independent advocates to guide families through treatment, complaints, and discharge processes.

m. During Darian's illness when he was still alive, we were let down by public services despite our peas for help. My above evidence has been in respect of EPUT, but I want to also make it clear that we were let down by other public bodies such as the Department for Work and Pensions and education authorities. Other services we used that let us down was our own mortgage company, **[I/S]**, who was aware of our struggles and prevalent safeguarding issues but aggressively pursued us for payment delays caused by our on-going struggles during our family crisis and then bereavement. When we complained to the Financial Ombudsman Service about them, they failed to take any substantive action. I consider that for wholesale change in mental health, services that interact with patients and their families also need to change. Companies such as this should not penalise families for delays or setbacks caused by trauma or bereavement. When service users do complain to

regulators, the investigations should be more transparent and thorough; and the premature dismissal of complaints should also be subject to more effective scrutiny.

Impact on me

391. After Darian died, I tried to be strong for the sake of my other children and Heidi. But I just could not manage it. I fell apart. I could not eat or sleep properly or function in any effective way for months.

392. I ended up under the care of EPUT myself as a mental health patient. EPUT have paused their treatment of me and I understand from a meeting I had with the Inquiry team in summer 2025 that the Inquiry is due to look into this. In December 2025, my GP referred me to another NHS mental health service given that I am still in need of mental health support and EPUT were not providing this care to me.

393. I think it is extremely important that this Inquiry looks into the ripple effect that suicide can have. Not only can it be daunting for those who lose their loved ones, but I assume that the ripple effect can also be very expensive for the NHS, in that those who are grieving may also end up needing mental healthcare as a result.

394. Nothing can be worse than losing your child in the way that I lost mine. I cannot be bothered to do anything. There are days when I just sit there and stare at the wall. I wake up and go to sleep with the same thoughts.

List of Documents which I have:

Please see the Annex of Documents

Statement of Truth:

I believe the content of this statement to be true

SIGNED . [I/S]

MR KOBAD BANKWALA

DATED 16/03/2026 .....