Witness Name: Julie Pashley
Statement No.: 1
Exhibits:
Dated: 20 June 2024

# UK COVID-19 INQUIRY

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## WITNESS STATEMENT OF Julie Pashley

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I, Julie Pashley, of Personal Data, will say as follows: -

1. I am the parent of a young person who was detained in hospital under the care of children and young people's mental health services (CYPMHS) between March 2020 and June 2021, when my daughter was 16 years old.

2. I make this witness statement in response to the Request for Evidence by the Chair of the UK Covid-19 Public Inquiry under Rule 9 of the Inquiry Rules 2006 (reference M3/JPX/01). I am grateful for the opportunity to assist the Inquiry with its examination of the impact of the pandemic on inpatient CYPMHS.

3. In May 2024, I was asked by MIND to provide a summary account of my experience of CYPMHS during the pandemic, as the parent of a young person who received inpatient care during the relevant period of the Inquiry's investigations. On 10 May 2024, I submitted my summary account to the Covid Inquiry through MIND, which has been incorporated into this statement. This statement was prepared with the assistance of Mind's legal team.

4. The facts addressed in this witness statement are from my own experience except where otherwise stated.

5. I am a mum of two from I&S (DOB PD). I work as a Family Ambassador for the NHS, working with families that have children in 'Tier 4'

impatient CYPMH units. These are mental health services for young people with more complex mental health needs requiring specialised inpatient care and treatment. I am also a member of a parent-carer support group called 'PLACE Network' which is run by the Charlie Waller Trust, a charity that supports young people and parents-carers facing mental health difficulties.

6. At the end of January 2020, my daughter, CB (DOB PD), who was 16 years old at that time, was admitted to a Tier 4 inpatient CYPMH unit at I&S I&S n I&S as an informal patient. CB had been diagnosed with autism spectrum disorder (ASD) and severe anxiety. She had developed self-harm and suicidal impulses and was struggling with low mood. I was not working in the NHS at the time.

7. When my daughter was first admitted to the Tier 4 ward in January 2020, most things seemed to function properly. The ward was designed to be a 'home away from home' for young people and their families, and the ward culture was open and friendly. Staff did their best to make patients feel comfortable; for example, staff dressed in casual non-clinical clothing. But things started to change around four weeks later when news of Covid-19 started to spread.

8. Towards the end of February/beginning of March 2020, things changed on the ward as everyone was becoming more aware of Covid-19 and its risks. The hospital put measures in place so that parents were no longer allowed on the wards. Masks had to be worn at all times by patients in the family room, hand sanitiser had to be used, and all staff were made to wear scrubs. No one was allowed on or near the ward if they had any symptoms of Covid. All the new rules were communicated to parents and young people as and when they were implemented, in a way that appeared chaotic and inconsistent at times. Parents were told that the reasoning behind the rules was simply for covid prevention and infection control, but some of the rules did not make sense at all, as I explain below.

9. On 18 March 2020, there was an incident on the ward where staff believed my daughter, CB, had swallowed a blade. Me and my husband were asked to pick her up from the hospital and take her to A&E at I&S on the other

side of I&S We were told that because she was leaving the ward, she could not come back for two weeks in case she contracts Covid. We were told that 14 days was the standard period of isolation for everyone. Knowing that we couldn't keep our daughter, who was extremely vulnerable at the time, safe at home, we begged A&E staff to do a Covid test as they were not rolled out as standard at that point. Thankfully they agreed, and the test was negative for Covid, so we took CB back to the ward. We asked if she could stay because we did not feel comfortable taking her home for unplanned leave, but the unit didn't agree.

10. There was a further incident when we were asked to take CB home because she had been coughing on the ward and the staff were concerned it could be Covid. They knew that CB has asthma and has had it for most of her life, and she was likely coughing due to allergies or hay fever, but they jumped on to Covid without any further assessment.

11. Despite not feeling comfortable doing so, we were forced to take CB home with us despite our obvious deep concerns that going home for two weeks was extremely risky for CB, who at that point had been limited to single-night overnight home visits. I was very concerned that her risk-taking behaviour had got worse, and would escalate, yet the clinicians thought she was well enough to go on unplanned leave. I felt the CYPMHS did not listen to me and my husband, and no one there seemed to take account of the potential risks posed by sending CB home for two weeks when she wasn't well enough to go home. No document was given to us explaining why she was being sent home, and as far as I was aware no formal risk assessment had been conducted. We were not explicitly told to call the police in case of emergency when we were sent home with an actively suicidal child. I was petrified. It was very disconcerting to see rules being applied blanketly with no regard whatsoever to risk assessing vulnerable young people.

12. My daughter felt very let down by the badly handled informal discharge. I didn't blame her for feeling like no one was listening to her when she had expressed that she was not ready to go home for more than one night. We took CB home and did our best to hide the anxieties we all felt.

13. On 19 March 2020, our worst fears were realized when CB ran away from home and attempted to jump off a bridge. It later transpired that she was so sure that her suicide attempt would be successful that my daughter had called the police herself before she left home that night.

14. We had dinner and played a few family games that evening and had just gone to bed when we heard the front door close, and immediately knew that something was wrong. When we realized that CB was missing, we tracked her location using apps installed onto our phones. We saw that she was near a bridge, and our hearts sank. My husband and I ran in opposite directions to look for her, and the police arrived shortly after we found her. We were on the phone to the Tier 4 inpatient CYPMHS at I&S for a long time that night, but they refused to admit her out of fear that she had Covid. We asked if they could put her in isolation but they refused to, stating that the isolation rooms were prioritised for patients that didn't have family. I found it puzzling that a mental health hospital was refusing to admit and treat an obviously unwell child who was at risk of seriously harming herself, when they could just put her in an isolation room for the required isolation period.

15. One thing that helped was the policemen that attended the call that night were brilliant. They helped us a lot. The police threatened to detain CB at the police station under section 136 of the Mental Health Act 1983 (MHA) to force the hospital to assess her, and the hospital eventually agreed to admit her and conduct a mental health assessment.

16. On Friday 20 March, CB expressed suicidal thoughts while an inpatient and asked to be discharged. She was placed under section 5(2) MHA while she waited for a formal mental health assessment. It wasn't until the following Monday that CB was formally admitted under section 2 MHA, which entitles mental health professionals to hold a patient in hospital for up to 28 days in order to conduct assessments when detention is seen as the most appropriate way of providing the required care and medical treatment. The consultant told us that CB was not going to be discharged within days as she was too unwell. That was reassuring to hear as it looked like a national lockdown was imminent. The first national lockdown was imposed the following week.

17. Despite CB's obvious need for mental health care and treatment, once assessed she was discharged within 24 hours. I argued with the clinicians over that decision, especially because she seemed to have settled on the ward since her admission and appeared to be responding well to treatment. The discharge note dated 26 March 2020 states that CB is "extremely vulnerable" and showed "risky and impulsive behaviour", but the hospital justified the decision to discharge her prematurely by saying my daughter had asked to go home and they were taking steps to limit "exposure to COVID-19 on the unit" since visiting restrictions were in place on the ward. My husband and I felt that the hospital wanted to 'clear the ward' in case of Covid-related emergencies. Clinicians said they felt that care in the community was in CB's best interest, but the only support she received in the end was over the phone. We were gobsmacked that CB was sent home again with limited care planning in place. We felt cross and anxious. It was chaotic. We felt really let down and worried about the potential risks from CB's impulsive behaviours. She was formally discharged from inpatient CYPMHS on 26 March 2020. It was day 2 of lockdown.

18. I felt that the second early discharge during the relevant period caused CB to lose trust in the hospital, the staff and the whole mental health system. I think it caused her to believe that no one saw or believed how unwell she truly was, and that had a negative impact on her mental health. It niggled on CB that she was kicked off the unit when she didn't feel ready to leave. I believe it contributed to an escalation and a third admission to inpatient CYPMHS during the relevant period.

19. It was also unbelievable that despite CB's asthma, as far as we knew she was not treated as a clinically vulnerable inpatient. Nothing seemed to have changed. I don't remember receiving any specific information regarding how her greater risk for Covid would be mitigated in hospital during the relevant period. The hospital's approach to dealing with such risks seemed to be to discharge seriously unwell patients whether or not they were ready to go home. This all reflects the haphazard way the rules around Covid were implemented.

20. In the first few months after being discharged, things were relatively stable for CB. I think because of her autism, she found it comforting knowing that socialising was restricted for everyone. She really tried to engage with community services but kept finding it difficult because most of the services were online or telephone-only.

21. CB's next admission to inpatient CYPMHS was again as an informal patient on 15 May 2020. This time, it was immediately clear that the rules around infection prevention and control were more rigid, but also more consistent. It was a short admission consisting of the provision of 72 hours' crisis support on the ward. CB made really good progress and was back home within two weeks. It was also clear that the care planning and wraparound support she received on discharge was much better third time around. She had almost daily home visits during this period. CB had regular appointments at home with an OT team and an Intensive Support Team from the community. The community link was brilliant throughout this period, and their care and diligence really impacted on my daughter. She was formally discharged from inpatient CYPMHS on 1 June 2020.

22. At home, CB tried to settle. She wanted to resume college in September 2020, but one sticking point for her was her worries around getting teacher-predicted grades for her GCSEs. She thought she would get low grades because she had spent a significant portion of Year 11 in hospital, and she was worried she wouldn't be able to get into college to study BTech Science. This uncertainty I think contributed to the deterioration of her mental health that led to her next hospital admission on 4 August 2020.

23. At this point in time the rules around Covid infection control were pretty set in and although there were regular changes, people were used to it by then. What was most confusing at the time was people's perception of the risks from Covid reducing significantly due to the loosening of restrictions, and the introduction of policies like the Government's 'Eat Out to Help Out' scheme. It was bizarre that we were allowed to take CB out for day trips to restaurants and cafes at the height of the pandemic. Whenever CB left the unit to come home, she would have to isolate when she went back on the ward until she had a negative Covid result. CB was very confused by those rules, and the isolation definitely had a negative impact on her mental health. Outside of Covid isolation, CB had good access to outdoor and

green spaces throughout 2020 while at I&S She also had good access to her mobile phone and other communication devices.

24. Another thing that was obvious at the time was the distancing effect created by staff wearing PPE and face masks at all times, which I know was necessary at the time. But I think it created further distance between staff and patients, and for autistic people like CB, it was already very difficult to connect and engage with staff. I know that some autistic people prefer to be around familiar people they trust, and that's certainly true for CB. It was also noticeable that from March 2020 onwards, staffing levels on the wards my daughter was admitted to were lower than before the pandemic. Some permanent staff were not available for weeks on end and were instead replaced with agency staff, which wasn't great for CB who struggles to trust and build relationships with new people. The chaotic changes negatively affected her mental health.

25. A further change I observed throughout 2020 was that most therapeutic support was being offered through remote means, including the parents' group that I attended. CB's community psychiatrist would only hold online consultations because it worked best for her, with no regard whatsoever paid to putting in place mitigations to meet my daughter's complex mental health needs. For someone who was emotionally dysregulated, it helps to see clinicians and therapists in person. It is crucial to building that important therapeutic relationship, but the community clinicians and family therapists refused our every request for in-person appointments. That blanket refusal didn't make sense to me as a parent. The impact on CB was significant and long-term because she refused to join any online therapeutic sessions and meetings where her voice could be heard, which meant that she couldn't access therapy in the community once discharged. Decisions about her care were made without her present. There was one key worker who worked within the Transforming Care service that does preventative work to reduce institutionalisation in young people with learning difficulties and autism who made a lot of effort with CB that really helped our family.

26. On 13 May 2021, following an overdose, CB was admitted to a hospital in I&S that was far from us because a bed couldn't be found for her nearer to home. CB was admitted under section 3 MHA, which authorises mental health professionals

to detain people requiring treatment for a period of up to six months. It was a two-hour drive each way to visit CB, but nothing could be done to move her closer to home. Our experience of that hospital was much worse than the hospital in I&S

27. To start with, the staff there were much stricter and appeared to be confrontational with patients at times. For example, we were not allowed to go inside the ward to see where CB slept. That was a strange feeling to have as a parent, and I worried about my daughter's safety. She wasn't allowed to take or send videos. The staff were overly formal and always wore full uniforms.

28. Further, rules around Covid prevention and infection control were applied inconsistently; for example, some staff would allow CB to go out for a cigarette, but others would not. The confusion caused by the inconsistent application of rules made her anxious. When CB was more stable, home leave was implemented. She had around 8 hours leave daily, but she had to isolate for 72 hours every time she came home for one night while waiting for a PCR test. When she was isolated on the ward she was not allowed outside, even on her own, due to Covid restrictions. Although this was sometimes relaxed by some members of staff and although we were grateful that she could get some fresh air, the inconsistency caused more issues. CB became so distressed on returning to ward that we decided to stop taking her home overnight in order to alleviate some of that distress, even though it meant that we faced longer drives. But we worried that overnight stays would have a massive negative impact on her treatment.

29. We were able to take her out to Southend and spend time in the car with her. Every day, we would drive for two hours to pick her up, for another two hours to take her home, then back again – a total of eight hours of driving daily – just so that we wouldn't be affected by Covid isolation measures. That seemed a little odd given we were spending four hours minimum in a car with her, in a much more enclosed space.

30. CB was discharged again from inpatient CYPMHS on 11 August 2021. She had said she wanted to live in supported accommodation, which we agreed to. We recognised that she needed her own space as she was almost an adult by then.

Social services said they had organised 'supported living accommodation' as part of her 'aftercare' support and rehabilitation package under section 117 MHA. We were told it had been agreed to in principle, but would not happen until two weeks post discharge, so we took CB for home leave for one week before she was officially discharged. Social care again confirmed that everything was in place, but the very next day they said they no longer had a placement for CB because she was about to turn 18 years old in I&S and once she was an adult, it would be down to adult social services to organise a placement for her.

31. My daughter felt very let down by that and ended up homeless. I do feel that had CB been able to spend more time at home on leave it might have prevented her from ending up homeless after discharge. We felt manipulated, as if the CYPMHS had made a calculated decision to get CB out of the hospital by whatever means necessary in order to free up her bed and save costs. I've seen this happen to other families. In my role as a Family Ambassador working in Tier 4 services, I now advise families in similar situations to stay put in hospitals until they receive the relevant paperwork and express confirmation of arrangements for community placements and support packages.

32. Between September and December 2021, we didn't know where CB was at all. I feel strongly that that risk could have been avoided because CB was entitled to aftercare services on discharge from detention under s3 MHA, so she should have had more support from services. Social services didn't seem to know what that entailed, so I had to print off information guides from MIND and Rethink Mental Illness to give to them. It was really disappointing to see services failing to communicate with each other. What is most dispiriting is I don't think that things have improved much post-pandemic.

33. I can say with my whole heart that the quality of care that CB received in the community was quite poor. A provider collaborative service that was commissioned by the NHS to run Tier 4 CYPMHS services and adult secure, perinatal and eating disorders services had taken over the whole region shortly before CB was discharged in August 2021, and adequate services were not in place until later that year. Case managers should have been available to provide

wrap-around care post-discharge from CYPMHS, but those roles were not in place until much later that year. There was no other provision for vulnerable young people with complex needs who fell through the cracks.

34. In reality, once CB was transferred to adult social care services, they should have taken over and put adequate support in place, including the provision of safe housing. I got the impression that the local authority didn't care much because it was felt that CB had made herself intentionally homeless and she had her parents' home to go to as an alternative. Social care ended up providing a flat ostensibly with 24-hour care on 1 December 2021, but only a low-level of support was provided. CB went into supported living with limited support provision because she had no other options. I was pleased that at least she would be safe, and I would know where she was, but I was too optimistic.

35. Throughout 2022, CB remained in supported accommodation but with low level of support. She kept asking for more support but it was not provided in person, which I think was a legacy of the pandemic. As a vulnerable young person who wasn't safeguarded by the local authority, CB's flat ended up being 'cuckooed' by a drug dealer who sexually assaulted and beat her over a three-week period. She became addicted to heroin and cocaine. No one from the community mental health team or social services visited to check on her, so no one saw what was happening. She had to go to the police to report what was happening herself. Out of all the other incidents that happened over the years, this was when we really thought we could lose her. In the end we had to get her the support she needed ourselves.

36. The failures by the community teams and social services could have been catastrophic. CB kept asking for help but she didn't get any. She was classed as a vulnerable adult, so I don't understand why she wasn't kept safe. We filed a complaint, but the services never accepted any blame. We thought about pursuing legal action, but my family were dealing with multiple bereavements during that period so we had limited capacity to pursue legal action against the mental health service or local authority.

37. Things kept escalating for CB until June 2023, when she jumped off a bridge and broke her spine in three places. Following a long rehabilitation period, she is doing

better and looking forward to resuming her education in September 2024. Adult social services took that incident seriously and she finally got the support she needed from adult mental health and social care services. She was moved to a supported placement with a higher level of support.

38. Overall, Covid restrictions prevented us from maintaining important links with our daughter and with community teams during the relevant period. My daughter's ASD diagnosis compounded the effect of the inconsistent approaches around Covid rules, which I believe worsened her mental health during that period. During the two years she was an inpatient in the two CYPMH units, from what I saw, the changes that were implemented to mitigate against Covid created confusion and distance, which I believe caused more harm than good overall.

## Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Signed**: Personal Data

**Dated**: 20 June 2024