Witness Name: Paul Steel

Statement No: 1

Exhibits:

Dated:

07/08/2025

THE LAMPARD INQUIRY

Witness Statement of Paul Steel

I, Paul Steel, will say as follows.

Preliminaries

1. My full name is Paul Steel.

2. I am making this statement in relation to my son, Adam William Steel, who died on 14 October 2021.

3. This statement sets out my understanding of Adam's mental health history including his interactions with Essex Partnership University NHS Foundation Trust ("EPUT"). It will provide a chronological account of the care and treatment he received and offer personal reflections on how his needs were managed.

Adam's mental health history and interactions with Essex Mental Health Services

4. Adam was 36 when he passed away, suddenly and unexpectedly, on 14 October 21 in the Peter Bruff Unit at Colchester Hospital.

5. He first had contact with Essex Mental Health Services in Loughton, aged 19, when he was diagnosed with Bipolar Disorder in 2004. We moved to Harlow in 2012 when he was under the care of the Derwent Centre at Princess Alexandra Hospital.

6. Since his diagnosis he had 4 or 5 severe manic episodes interspersed with periods of depression. Although he was blighted with the chronic illness it never became a burden to him or define[d] his life. In fact, he always managed to hold down full-time employment as a leisure attendant and swimming teacher with very few periods of absence through illness. He was well supported by his management teams.

7. In April 2014 he was admitted as an inpatient at the Derwent Centre, Harlow following a manic episode. He spent 3 weeks under the care of consultant psychiatrist Dr [I/S] who Adam had a very good rapport with. On discharge he remained as an outpatient under that psychiatrist who provided excellent care and support to Adam, and as a family we had nothing but praise for him.

8. In 2018 Adam was married. Shortly after he was diagnosed with testicular cancer but had been in remission post operation and treatment.

9. He remained well until September 2021 when he probably had his worst manic episode since his initial diagnosis. This was brought on by a combination of things. Him and his wife were about to embark on a course of IVF treatment, he was going for a promotion at work and he was also trying to address his weight issues.

10. He couldn't cope and subsequently had a breakdown. He was anxious, agitated, not sleeping and wandering the streets. He would sit in the garden in his underwear in the rain. Although he could be verbally abusive he was never aggressive, violent or self harming. He was more of a danger to himself rather than others. With persuasion he could be compliant.

11. By early October his behaviour was becoming more erratic and his wife and family were finding it difficult to cope. We contacted the Harlow Crisis team for help and the Home Treatment team attended to assess Adam. It was agreed

that he needed admission but there were no beds available at the Derwent Centre in Harlow.

12. Adam was keen to be admitted there as he was familiar with the staff and surroundings. The Home Treatment team attended for 5 days to administer medication and observe him. We were told that a bed would be available the following day at the Derwent Centre.

13. A different Home Treatment team attended on 13 October 21 and stated that the only available bed was in Colchester, 50 miles from his home and family.

14. However by this time, after a 5 day wait, Adam was desperate for help and would have gone anywhere in order to be treated and get better.

15. His wife and I took him voluntarily to the Peter Bruff Unit, Colchester Hospital and he was admitted at 4pm on 13 October 21. The following morning at 8am on 14 October 21 he was found unresponsive in his room. His wife was informed shortly afterward, by phone, that Adam had passed away. I felt this was a particularly unprofessional way of informing her due to the fact it was sudden and unexpected in nature. The member of staff even managed to get his wife's name wrong. A visit by the local police to inform her would have been far more appropriate. Fortunately, she was with her family when the news was broken to her.

After Adam's death

16. Adam's postmortem was inconclusive and further tests were carried out. The final cause of death was given as multiple organ failure allied to obesity. We were totally unhappy with this verdict as he was only an inpatient for a total of 16 hours and had been admitted physically well.

17. I instructed a solicitor shortly after Adam's death who themselves consulted a cardiologist, Dr [I/S], to examine Adam's medical history and the lead up to his death. His subsequent report, dated 5 May 24, disagreed with his cause of death. He stated that the cardiac arrest was due to history of arrhythmia (I have a copy of the cardiologist's report together with the postmortem report and death certificate, should they be required).

18. I made a complaint against the Trust who instigated a hospital investigation. This was carried out by [I/S], Clinical Lead Palliative Care, and Dr [I/S], Consultant Psychiatrist. This report was not completed until 6 May 22 and I did not receive a copy until 28 June 22, 8 months after Adams passing.

19. I would like to highlight some of the points within the report, which I consider to be a complete let down in the care that Adam received during his short stay as an inpatient.

    19.1. Adam was not once checked physically overnight.

    19.2. Total reliance on camera observations only, contrary to Trust policy.

    19.3. His bed could not be seen through the observation window of his room, due to its location. Even more reason why he should have been physically visited face to face.

    19.4. Lack of staff.

    19.5. Discrepancies in relation to the timing of events when he was found unresponsive and when his door was opened.

    19.6. Wife advised by phone call of his passing rather than personal visit.

My reflections about Adam's care and treatment, and recommendations

20. I feel that if Adam had received proper care and attention the outcome of his sudden, unexpected and untimely death may have been different.

21. I would ask that the following observations and recommendations be considered:

    21.1. Admission to hospital as close as possible to home address and family.

    21.2. Patients to be visited face to face at regular intervals rather than total dependence on technology.

    21.3. Beds to be in view through observation window.

21.4. Next of kin to be advised of bereavement personally, rather than over the phone, particularly if it was sudden and unexpected.

I believe the facts stated in this witness statement are true.

Signed: [I/S]

Date: 7-8-2025