WITNESS STATEMENT OF MS JANE MAIER PURSUANT TO RULE 9 REQUEST FROM THE LAMPARD INQUIRY

1. I, **MS JANE MAIER**, DATE OF BIRTH [I/S] of [I/S] [I/S]

2. This statement is in connection to my brother Daniel Fairman's treatment under Essex Partnership University Trust and his death. I am making this statement based on my memory of events and from having read the documents I have mentioned in the 'Documents I have' section. I have identified key documents for the inquiry to obtain. Further to the receipt of the same, I would like to submit further rule 9 statements.

Diagnosis and contact with professionals in relation to his mental health

3. To my knowledge, my brother Daniel Fairman's (Dan) mental health issues started in early 2017. Initially, he saw several different private therapists but none of these appointments helped him. No one gave him the support he required. It seemed as though Dan was going from one specialist to another and was not getting better. I therefore told Dan to see one clinician / psychiatrist who can help him address all his mental health concerns rather than seeing different specialists.

4. As Dan was increasingly staying with my mother at the time, we looked for mental health services in Essex. Dan had medical insurance, so in the first instance we went to the Priory in Essex. Dan was under the care of the Priory from March 2018 – May 2018.

5. As per my recollection, Dan's first consultation at the Priory was with Dr [I/S] [I/S] in March 2018. I went with Dan to this appointment. I recall Dan explaining to Dr [I/S] that he was taking two types of medication, one of which was [I/S] and another tablet (the name of which I do not recall) which Dan felt that did not work for him. Dr [I/S] said that he would prescribe alternative medication for the one Dan found less effective and suggested Dan to try '*upping the dosage of the* one of the medications' by almost 3 times to 200mgs. The dosage Dan was previously on to my recollection was 25mg to 75 mg. Dr [I/S] gave no advice on how quickly this increase should take place or what he meant by '*try*' . Dr [I/S] then went on holiday for two weeks and was out of contact. I felt there was a lack of proper guidance and support from Dr [I/S] at this point. To my mind it is imperative that clinicians reassure both the patient and the family members that treatment will continue with another clinician and that

the notes will be passed on to the doctors covering Dr [I/S] whilst he was on holiday.

6. To my knowledge, Dan increased his [I/S] dosage as per Dr [I/S]'s advice, took other medications and immediately these took effect. His mood spiralled out of control. To my knowledge he did not have paranoid delusions before he took these medications. I do not feel that Dan was given any specialist advice on effects of different medications, when they start working and whether Dan should be careful when mixing different tablets.

7. In the absence of Dr [I/S] I tried contacting the Priory for advice, and I was finally contacted by a Doctor (the name of whom I do not recall) who said Dan's extreme anxiety *'might be an effect of the Lyme's disease'* that Dan was diagnosed with. I would like the Inquiry to know that we as a family were desperately trying to understand what was happening to Dan, but no advice was given from anyone. Dan became increasingly agitated and he told my mother that he felt extremely unwell and that *'he would do something'*. She took him twice to Broomfield A&E but he wasn't admitted to the hospital. Following the two trips to A & E Dan was eventually admitted to the Priory as a private patient. From this time onwards Dan did not stop having what I understood to be paranoid delusions, though the Priory Team felt the medication Dan was prescribed had improved his symptoms in relation to depression. Dan attempted to take his life several times whilst at the Priory. All of us feel that the staff should have considered sectioning Dan when he was trying to take his life on multiple occasions as an inpatient at the Priory. I believe that Dan being sectioned would have meant that we would have been informed about his mental health more substantively. It is worth noting that we were still unclear of Dan's diagnosis.
8. I was advised that Dan's BUPA cover was imminently due to expire and the Priory recommended we visit the psychiatric team at the Chelmsford Hospital to see if they would take Dan. On 23rd of May I received a call from the Priory hospital to say that an ambulance had been called to take Dan to Colchester Lakes Hospital. Before I made contact with the Chelmsford hospital, Priory had already made arrangements to transfer Dan to Colchester Lakes hospital without our input. I can only assume that this may have happened either because Dan no longer had the cover for private treatment or alternatively it may be that they deemed him slightly difficult to handle and hence thought a transfer would be appropriate even though they did not consult his family regarding this transfer. This is another reason why I would like sight of all of Dan's medical records to see what actually happened.

9. This is two hours from my home in London and over an hour's drive for my elderly mother and yet we were given no option of stopping this move. My elderly mother was extremely distressed at being so far from her son and it was always really difficult for her to get to see him. The family were left feeling totally let down by a system that gave us no choice or input in Dan's care.

10. Dan was transferred to Gosfield ward at Essex Partnership University Trust from 23rd May 2019 until 15th August 2018, when he was discharged. He died on 17th of August 2018, **within 48 hours of discharge.**

11. **A Root Cause Analysis (RCA) investigation report looking into the circumstances surrounding my brother's death was completed in December 2018.**

12. The RCA report states that Dan was *'diagnosed with anxiety / depression'*. I would like to inform the Inquiry that we as a family were never informed of Dan's diagnosis. He was under the care of specialist psychosis team at the time of his death and this team as per the RCA report is *'for adults who have an established diagnosis of schizophrenia / bipolar disorders with a history of psychotic symptoms'*. I appreciate that I am yet to see the medical records, but in the absence of the same I would like to know if Dan was ever formally diagnosed with schizophrenia or bipolar. If so, this was not communicated to us as his family members. The RCA report also states that Dan was diagnosed with *'delusional disorder'*. Again, I do not however recall Dan being given any formal diagnosis that would have helped us as his family to look after him.

13. We were never informed about what to look out for, how to cope when Dan's mental health would deteriorate or what questions to ask to understand how best we as a family could support Dan, more than what we were already doing.

14. I do not feel that Dan's symptoms were understood by the clinicians treating him. Dan was constantly paranoid and thought he deserved to be an inpatient at the ward, which he thought was a 'prison'. Dan was absolutely convinced that he was a rapist, and that his 'punishment' was to be a prisoner, i.e an inpatient in the mental health ward. He did not understand that he was in a mental health ward where he was being treated for his mental illness. I do not understand why the doctors did not take into consideration Dan's concerning behaviour. Dan had extreme suicide tendencies, and it was critical for the doctors to understand how Dan's mind worked. Dan had attempted taking his life **multiple** times. For example, he ligatured on multiple occasions which then led to ***'visible discoloration to his face, marks and imprints on his neck' and attempting to 'puncture his neck and his head*** **[I/S]** He had informed the staff at Gosfield ward that he had previously ligatured *'at least 14 times'*. On 3.06.18 it was reported to staff that Dan ***'was writing a book on how to end his life'.*** I would like the inquiry team to investigate why this was not taken seriously, and why as Dan's family members we were not informed of this information.

15. The RCA report states *' A formal request for notes was made to the Priory hospital in Chelmsford, records covered period* ***22 March 2018 to 23 May 2018****. This included letters from outpatients' appointments with Consultant Psychiatrists, discharge summaries, medication chats, care notes and observation sheets.'* However the RCA report then goes on to state that *' Mr F was transferred from the Priory Hospital to Gosfield ward, review of the medical records show that up to date risk assessment, care plans and care notes*

*(**16/05/18 – 23/05/18**) were handed over to Gosfield team.'* I would like the Inquiry to look into / investigate as to why **not all** of Dan's medical notes were handed over to Gosfield ward upon his transfer. This to my mind is a huge concern, as the staff at Grosfield ward would not have had a clear picture of Dan's mental health history when he was transferred.

16. The RCA report states that we (Dan's family) attended *'meetings on the ward'*. I would like to add here that we as a family always felt that these meetings were never helpful. Dan would be present in these meetings and he would be spoken about like a number. These meetings were not conducted with any dignity and we always felt uncomfortable being part of such meetings.

17. The RCA report states that Dan had a *'good period of leave with his sisters without any concern'*. This is incorrect, as we were always scared that Dan would continue making attempts to take his life. He once pointed out a killer mushroom, when we were on a walk and said that would be enough to 'kill' him. In addition to this, I recall that Dan went to my sister and brother in law's house and he was caught looking for my brother in law's gun, which was locked away in a gun safe. These were all worrying behaviour that deeply concerned all of us.

18. The RCA report, states that on 15.08.2018, Dan had *'no thoughts of suicide'* and that *'he was not brave enough to do such a thing'*. Dan died on the 17th of August 2018, **within 48 hours after he was discharged.** To this day the rationale behind Dan's discharge is something we do not understand. Dan had previously said that he was *'not brave enough to do such a thing'* i.e take his life and was noted to have said that he was *'not able to go through with these attempts'* as he thought he was a *'coward'*. Why did Dr [I/S] (who was in charge of Dan's care at the time) not take into consideration that Dan had tried to take his life the same week when he was discharged? Dan had attempted to take his life by jumping from a high wall of the roof within the hospital grounds, on the very week he was discharged. During one of the early consultations for which I was present … Dr [I/S] asked Dan *'are you a rapist'* in front of me. My obvious question here is why did Dr [I/S] not read Dan's medical notes prior to meeting Dan?

19. The RCA report quite clearly shows that Dan's mood had been fluctuating. This to me means that treatment was not working as it should have. Dan has also been noted to say that he himself felt that his medications have not been helping him and yet one of the reasons cited for his discharge was that Dan was *'compliant with medications'*. I would like the Inquiry to investigate whether the medications prescribed to Dan were in keeping with his symptoms and whether the medications would have made any difference to him.

20. The RCA report states that a 48 hour *'follow up call'* was completed by an agency staff nurse on 16.08.2018 at 14:45 pm. I do not have the medical records to hand. I do however have concerns about the quality of this call. During the first 48 hours OF discharge, my mother asked me to call Dan as he was not feeling good. I called Dan and he said that *'he was feeling very strange and peculiar'*. I

told Dan not to worry and that he will feel disorientated coming out of hospital. I had no guidance from anyone at the Trust as to the warning signs to look out for. I did not know what to say to Dan but I did my best to reassure him without any medical guidance from the hospital as to warning signs to look for when someone is discharged from a mental health unit. I believe that Dan was trying to tell me that he was going to take his life and this was his cry for help. The RCA states that Dan reported he was 'doing well' when he received a call from the agency worker. The RCA report however then goes on to say that :

'...There is very little information available on the details of the call, the information was not recorded contemporaneously and the staff member entry was made on behalf of the staff member by another staff member with access to Paris. There are a number of lessons from this.

a. Follow-up calls should address areas relevant to identified risk and should include a mental state examination unless contraindicated.

b. Follow-up calls should be documented by staff with access to the electronic Mr F records.

c. Follow-up calls should be documented contemporaneously...'

21. The above leads me to believe that the call to Dan did not amount to actual follow up and was instead a simple tick box exercise to document that some sort of contact was made with Dan. Clinicians ought to have known that patients tend to be the most vulnerable around time of discharge and I therefore want the inquiry to investigate why it was acceptable to record minimal information about the discussion with Dan on 16.08.2018. What does 'doing well' mean? Why was it not taken into consideration that patients suffering from mental health illness often hide their emotions and aren't always being truthful. Dan was known for being difficult when it came to engaging with mental health services. Why was none of this taken into consideration by the staff?

22. The RCA report also notes that the Agency staff member that made the *'follow up'* call 48 hours after discharge did not have temporary *'access to Paris / Remedy'*. My understanding is that the Paris / Remedy is a system that would have held Dan's medical records. If this is the case, then I would like the Inquiry to look into why the Agency staff did not have access to Dan's medical notes. Would the follow up call have been conducted differently, had the staff who completed the follow up call been completely aware of Dan's mental health history?

Ward Environment

23. Dan would lay around a lot when he was inpatient, and Dan had told me that he had a few outings. I do not know much about the ward environment because the staff did not give us much information about Dan's day to day life as an

inpatient. I heard about some activities that the Trust had for the inpatients, however Dan did not take part in any of this as he was not interested in any of this. To my understanding the staff did not make any attempts to understand Dan, learn about his likes and dislikes. I feel that if the staff had made an attempt to understand Dan on a more personal level, he may have benefited from more of a tailored treatment. He was a huge extrovert and wasn't introverted at all and so given the right environment and interest, he could have been worked.

Discharge and Continuity of care and treatment in community

24. To my mind, the decision to discharge Dan from mental health services was by far the worst decision the clinicians (Dr [I/S]) made. The clinician's involved in my brother's case knew that my mother was 83 at the time Dan was being discharged. She was elderly and vulnerable, and in our view it was wholly inappropriate for Dan to be discharged to live with his mother. More so, because we had previously expressed concerns over my mother's safety, if Dan was discharged to live with her. If Dan had a psychotic episode, there is very little my mother would have been able to do to stop him.

25. The RCA report says ' *Mr F was reviewed by MDT, family members were present and agreed Discharge to mother's address* '. In the first instance, I was the **only** family member attending this consultation. I am appalled at the fact that the RCA report has got such an important detail incorrect. I was not asked whether I was happy with this sudden decision to discharge, and instead I was simply told that Dan would be discharged.

26. We also did not have time to prepare for discharge, and the profound agony and distress we faced as a result of having Dan's discharge sprung on us last minute is something I cannot put into words.

27. I would also like to know as to why the Specialist Psychosis Team (SPT) thought it was necessary to only contact Dan in a weeks' time after discharge. Given Dan's mental health history, I would like to know why the SPT were not asked to contact Dan earlier. Dan was being treated under the psychosis team and to my mind it is unacceptable that the SPT were only required to contact Dan within a week of discharge. We know this method does not work because Dan died within 48 hours of discharge.

28. The discharge meeting recording on 15.08.18 suggests that there was *'...no qualified nurse in the discharge meeting and the risk assessment was updated by an unqualified member of staff who was recorded to have attended the ward review. A review of health roster suggests that there were at least two qualified members of staff available on the ward as well as the ward manager.'*. I would like the Inquiry to look into why this happened.

29. The care coordinator was supposed to meet us before Dan was discharged as per the discharge plan. This did not happen. I would like the inquiry to investigate as to why this did not happen.

Quality of investigations undertaken or commissioned by healthcare providers:

30. I would like to inform the inquiry that we as a family feel that the Trust behaved appallingly further to my brother's death. I attach as Exhibit A an email I sent to the Trust on 18th April 2024. I have also attached Exhibit B which is the response I received from the Trust to my email dated 18th April 2024. As you can see [I/S] [I/S], who works on the action plans following a Root Cause Analysis investigation at EPUT had said that the health Authority would contact us to discuss matters 48 hours after the inquest. This did not happen.

31. On 13th September 2024, a zoom meeting was held with my brother Nicholas Fairman (Nick) and myself. I do not know if this meeting was recorded, but if it was I would like the Inquiry to request a copy of this recording. I would also like the Inquiry to obtain the minutes of this meeting. Firstly, a meeting should not have happened several years after my brother's death. I had to explain everything again in this meeting and this in itself was very difficult. My brother Nick queried as to why Dan was never sectioned. We did not get any response to this. I recall saying at this meeting that if a person was coming home after heart surgery the family would be given advice on how to care for them and the family will be provided ample information on safety of the patient. If a Rumanian abandoned dog was being adopted in the UK, the dog would have had the new home checked for wellbeing and safety and yet my poor obviously mentally unwell brother was abandoned into the care of an elderly woman with absolutely no consideration being given to his care and safety at all. They had no response to give me except that 'things have changed now'.

32. The RCA report states that *'an abbreviated anonymised summary will be shared with staff teams trust wide to widen the learning opportunities'*. I would like the inquiry to find out if this happened and whether any actions resulting in change happened.

33. I understand that the RCA report was distributed to the following :

- Executive Director of Mental Health & Deputy CEO
- Executive Medical Director
- Executive Nurse
- Deputy Director of Nursing/DIPC
- Director of Mental Health
- Head of Incident Management
- Clinical Commissioning Group
- Care Quality Commission

34. I would like the inquiry to look into any responses the Trust may have received from those listed above. If so, I would like the inquiry to obtain a copy of the responses received.

Recommendation for change:

35. There are many areas of mental health care that the Trust will need to change to see a drastic improvement in patient care:

    In my view Essex Partnership University Trust should ensure that:

    35.1 Patients have dedicated clinicians, nurses and Health care support workers as this avoids unfamiliar staff treating patients.

    35.2 During transfer, the systems should be advanced enough to ensure that all medical notes are transferred from one ward to another.

    35.3 Key information like co-morbidities, warning signs, and patients attempts to take their life should be highlighted at the top of every patient's record. This should immediately alert staff to the patient's history.

    35.4 Communication with family is critical at every key stage of any patient's treatment.

    35.5 When a patient is discharged, their family should be informed about :

    - warning signs to look out for
    - how best to cope when the patient's mental health deteriorates, and
    - when to seek medical attention

36. The RCA report lists the below recommendations:

    36.1 Inpatient Team to communicate clearly the discharge plans and actual discharge date to family, community teams and patients.

    36.2 A qualified nurse to attend ward reviews for patients that are to be discharged.

    36.3 48 hour follow up to be completed according to patient risks and care plan when completed it should follow the following criteria:

    a) Be by a member of staff with access to the electronic patient record

    b) Be recorded contemporaneously

c) Follow a template which should cover the main aspects of the care plan and this should include established areas of risk

d) Where possible be by the member of ward staff that knows the patient well (e.g keyworker)

e) Temporary staff to have access to temporary login for Paris (Electronic record system)

f) Clinical coders should discuss their diagnoses with the treating consultant prior to recording them in the electronic patient record.

37. I would like the Inquiry to find out if the above recommendations were implemented.

Quality of investigations undertaken

38. Whilst I have quoted several parts of the RCA report, above I would like to inform the inquiry that my personal view is that this report was insufficient as the report simply does not take into consideration what we went through as a family. The report does not reflect the distress we went through as a family, and how we were left with very little information on Dan's condition. The RCA report also mentions that the *'patient's family were contacted as part of the investigation.'* I would like to inform the inquiry that no contact was made.

39. I am in receipt of the Serious Incident (E117284) Action plan which details the actions required further to the recommendations made in the RCA report. The target date for recommendation 1 2 and 3 is noted to be February 2019 and the target date for recommendation 4 and 5 is noted to be March 2019. I would like the inquiry to investigate whether the target dates were met. I.e did the Trust execute the actions required as per the Action Plan?

40. The RCA report states that Dan *'was found hanging at 'his home address in his garage'.* This is incorrect as he was at his mother's address. Why has the Trust made errors in this report that is suppose to look into my brother's death?

41. I would like the inquiry to obtain all the disclosure listed below:

41.1 Medical Records from the Priory Hospital, Essex in order for me to have sight of all the key dates and entries in records. This will give a clear picture as to what treatment my brother received, and how things were recorded.

41.2 All EPUT medical records (to include records from Mid Essex, Colchester, Chelmsford, Broomfield). This is critical disclosure without

which I cannot be sure of the dates of different consultations my brother had.

41.3 GP records so I can see how often the Trust corresponded with Dan's GP and also to be able to view key dates regarding my brother's treatment.

41.4 EPUT clinical Risk Assessment procedures (15th June 2017) CLPG28 so a review can be done on whether these procedures include everything they ought to include.

41.5 The Inquest documents to include, the inquest transcript, reports and any statements by witnesses called and read. We were unrepresented at the inquest, but nevertheless valuable evidence was heard at the inquest including the coroner stating that there were 'serious errors' in the care my brother received.

41.6 CPA & Non-CPA Policy (15 June 2017) CLP 30 as mentioned in the RCA report so we can consider and review the policy documents referred to when the RCA report was being prepared.

41.7 EPUT Suicide Prevention Procedures (21 July 2017) CG 29 as mentioned in the RCA report so I can see what the prevention procedure says and whether the staff responded in accordance with this.

41.8 EPUT suicide prevention procedure in place at the time of Dan's death in case the above document (no 7) is different to the one in place at the time of Dan's care and death.

41.9 The minutes of the debrief conducted with 12 staff members from the inpatient services post Dan's death, as mentioned in the RCA report. I would like to review this document to see what each staff member recalled regarding Dan's care.

41.10 The minutes of the debrief facilitated by the clinical psychologist attended by the care coordinator post Dan's death I would like to review this document to see what each staff member recalled regarding Dan's care.

41.11 A copy of the witness interviews from staff involved in Dan's care as mentioned in the RCA Report. This is critical disclosure and must be obtained so we can review the level of understanding the staff had regarding Dan's mental health conditions.

41.12 A copy of the interviews and statements from relevant stakeholders and agencies including Dan's consultant and staff nurse who

completed the 48 hour follow up. (these documents appear to have been obtained by the Trust to complete the RCA report). I would like the inquiry to obtain this for the same reason mentioned in point 11.

41.13 Statement from Dan's Care Coordinator (as mentioned in RCA report) for the same reason mentioned in point 11.

41.14 Minutes and recording of the meeting between myself, my brother Nicholas Fairman and the two representatives of EPUT that took place via zoom on 13th September so the inquiry can see how we were left without satisfactory responses to our questions.

41.15 The following have been mentioned as information and evidence gathered to prepare the RCA report. I would like the Inquiry to obtain the below to review internal documents in relation to mental health care and also Dan's care :

- Policies and Procedural Guidance
- National Guidance
- Training records
- Health roster
- Safer staffing
- Staff interviews

42. The documents I have:

42.1 Root Cause Analysis Report (RCA report)

42.2 Action Plan (E117284)

42.3 Record of Inquest

Statement of Truth

I believe the content of this statement to be true

SIGNED [I/S]

MS JANE MAIER

DATED 07/04/2025