IN THE LAMPARD INQUIRY

OPENING STATEMENT ON BEHAL OF CORE PARTICIPANT, MICHELLE BOOROFF, REPRESENTED BY IRWIN MITCHELL SOLICITORS

A. Introduction

1. This opening statement is made on behalf of the Core Participant ('CP'), Michelle Booroff, represented by Irwin Mitchell solicitors.

2. Ms Booroff is a CP by virtue of her son, Jayden Andrew Booroff, having tragically died on 23 October 2020 further to absconding from the Linden Centre in Chelmsford, run by Essex Partnership University NHS Foundation Trust ('EPUT'). Jayden was detained under section 2 of the Mental Health Act 1983 at the time of his death. Ms Booroff has not yet provided a commemorative and impact statement to help the Chair understand who Jayden was, though she very much hopes to be able to do so in due course. This is largely due to how difficult, and traumatic, writing such a statement is.

3. We very much hope the Chair will hear directly from Ms Booroff about her son, whose life was tragically cut short. We use this opportunity now to give the Chair a very brief introduction to Jayden.

4. Jayden was 23 years old, when he tragically died. He was a much-loved son, brother, nephew and friend. He adored music, singing, and musical theatre. Hearing Ms Booroff speak about Jayden, it is obvious that he was an empathetic, kind, happy, fun, and talented young man. He had hoped to travel more in his future, and could be a very spiritual and philosophical person. He loved wildlife, helping the people around him, singing with his mother, performing, and thinking deeply about the world. Those who knew him still tell Ms Booroff now what a beautiful soul he is.

B. Background

5. The Inquiry is at an early stage. The Chair will, hopefully, come to hear detailed evidence about Jayden's treatment and care, or lack thereof, during his time as an inpatient under EPUT. That evidence will not be rehearsed here, save as to provide the Chair with an understanding of why Ms Booroff has chosen to participate in this Inquiry, and the truths she hopes to uncover in doing so.

6. Jayden's experiences, sadly, raise a multitude of concerns falling within several of the Terms of Reference and Provisional List of Issues. In relation to the Chair's proposed approach to potentially pick a sample of cases in order to investigate these issues, we request that the Chair considers using Jayden's experiences within this sample.

7. Jayden's mental health began to deteriorate towards the end of 2019 and beginning of 2020. Ms Booroff, like so many families, battled, alone, for months, trying to support Jayden with his mental ill health. Ms Booroff sought help as Jayden's mental health became increasingly poorer. She experienced countless examples of being ignored, discredited, dismissed, and made to feel like she was an overbearing, interfering mother when seeking this support. Even when Jayden was brought

to A&E due to his concerning and alarming mental health presentation, her concerns for Jayden were dismissed and Jayden was sent home for treatment despite her pleas for him to be placed in a safe environment due to his acute psychosis.

8. Ms Booroff describes this period of time as a period of significant delayed intervention. Ms Booroff will forever question how things might have turned out for Jayden had he received the early intervention he needed and deserved, and that she had sought for him.

9. In September 2020, Ms Booroff was finally able to convince mental health professionals within the Trust that Jayden required urgent help. This led to his admission to The Lakes, in Colchester.

10. Ms Booroff fought hard and tirelessly for Jayden to be placed in The Lakes. She placed her trust in EPUT to care for her son. This trust now appears to Ms Booroff to have been misplaced misguided. She should have been able to trust EPUT, and initially, she did. She believed Jayden would be safe once under the care of professionals, whose duty it was to provide compassionate, caring, and responsible treatment and care to her mentally ill son. She now cannot understand how she could have believed that would be the case. She now experiences feelings of guilt that she pushed so hard for Jayden to be admitted to hospital.

11. Whilst detained in The Lakes, Jayden would call Ms Booroff, telling her how scared and disturbed he was by the behaviour of staff towards, and in front of, patients. He described staff playing cruel mind games with patients, tormenting and teasing them. He described how staff would sit back and watch fights break out between patients, instead of intervening. When Ms Booroff would visit Jayden, waiting in the reception area she overheard members of staff complaining about patients. When his mental health deteriorated further, and he was later detained in the Linden Centre, Jayden told his mum about staff taunting him. Ms Booroff was torn and did not know what to believe; she had thought her son had gone to a place of safety to be cared for. She knew he was unwell. She hoped that what he was reporting to her was a symptom of his psychosis, rather than his reality.

12. The Chair will hopefully come to hear evidence about Jayden's premature and rushed discharge from The Lakes. The issues of discharge planning, care planning, communication between services, and communication with family members and patients are important and key themes falling within the Inquiry's Terms of Reference. Sadly, these are all issues that directly and routinely reflected Jayden's experiences with EPUT.

13. Ms Booroff had significant concerns regarding physicians' medication and prescription decisions for Jayden during his detention at the Linden Centre. Ms Booroff is keen to ensure that the Inquiry investigates such decisions made by the Trust. During Jayden's short period of involvement with EPUT, he was prescribed medication against his wishes and in spite of concerns raised by Ms Booroff regarding their necessity and efficacy, and potential side effects.

14. After a short period of living back in the community, with little to no effective support from the relevant mental health services, Jayden came to be detained in the Linden Centre. Sadly, he absconded only a few days following his admission, and died the same evening he absconded.

15. Whilst detained in the Linden Centre, Jayden was incredibly mentally unwell. He was suffering with psychosis and disclosed on numerous occasions his thoughts of ending his life. He was often non-sensical in his speech and spoke to Ms Booroff at length about moving to the next realm. He

had become paranoid, scared, and confused. He was presenting a very high risk to himself and staff knew he was not safe to leave the ward. However, on 23 October 2020, Jayden followed a member of staff through three secure, locked doors, and out of the Linden Centre. Within 2 hours of escaping, he had been struck by a train and tragically killed. Essex Police failed to classify Jayden's AWOL as being high risk, due to poor and incomprehensible communication between EPUT and the police.

C. Issues and concerns

16. Ms Booroff had, and continues to have, considerable concerns about the circumstances of Jayden's detention in The Lakes and the Linden Centre, and his treatment overall under EPUT. We seek to provide here a brief overview of those concerns, as they relate to and inform the Chair's Terms of References and Provisional List of Issues. Given the early stage of the Inquiry, this is an overview only which inevitably will require further detail, evidence, and consideration as the Inquiry progresses.

17. Ms Booroff is encouraged that the majority of her concerns have been identified in the Chair's Terms of Reference and Provisional List of Issues. She echoes the sentiments put forward in the opening statements of other family core participants and the charity INQUEST in outlining the importance of thorough investigation of those concerns and issues. The breadth of the issues arising in relation to Essex mental health services' care and treatment of patients is alarming. In order to avoid repetition of already well-aired concerns and issues, Ms Booroff's concerns are listed concisely below, and are identified as they relate to Jayden's history.

18. Those concerns include:

    a. Staff's failure to understand Jayden's complex mental health presentations. Ms Booroff witnessed, throughout the period of Jayden's involvement with EPUT, a lack of professional curiosity to understand Jayden's complex mental health presentation. Assumptions and presumptions were made as to his concerning presentation, leading to worrying clinical decisions including failures to admit Jayden to hospital, prescription of medications Ms Booroff and Jayden did not agree to, and incomplete risk assessments.

    b. Staff attitudes and stigmatisation regarding addiction. Jayden suffered with various addictions, alongside his other mental health conditions. The Provisional List of Issues outlines that this Inquiry will investigate how factors including drug and alcohol addiction were considered and subsequently managed. Ms Booroff's experience was that Jayden's addiction was not managed, but rather used to explain his behaviours and justify a lack of treatment. Ms Booroff was left with the distinct impression that Jayden was being blamed for his presentation due to his addiction and this was something he would need to overcome before he would be deserving of treatment. Ms Booroff has considerable concerns as to systemic and deep-routed attitudes by Essex mental health services' staff regarding addiction, and its management in the nexus of care treatment.

    c. Poor record keeping and general care management, and failures of handover and communication between staff. The management of Jayden's care records was inconsistent at best, with outdated care plans and risk assessments. Risk information often was not

communicated or updated between teams, and from Ms Booroff to staff on the ward. This included information about Jayden's risk of absconding, which was not shared to staff on the ward where he absconded from. Concerns about record keeping in relation to Essex mental health services have sadly been regularly documented and raised in Inquests, CQC inspection reports, and other investigations. Pertinent and important information regarding Jayden's suicidal thoughts and intentions to abscond were not handed over between staff and team members when Jayden was detained at the Linden Centre. Moreover, the information shared by Ms Booroff often was not adequately recorded. Ultimately, staff had an incomplete and misinformed picture of Jayden's risk and care needs.

d. Discharge planning and decision making for inpatients. Jayden was discharged with no updated care plan, in a very rushed manner, and amid confusion and uncertainty regarding the community team and after-care support he was being discharged into. This exacerbated his, and Ms Booroff's, feelings of being alone to support Jayden in a time of high and complex need. In particular, the Chair's questions in her Provisional List of Issues relating to whether discharge procedures were followed, the appropriateness of discharge, and whether all available and necessary information known at the time of discharge was available are of concern to Ms Booroff.

e. Lack of consistent staff members on the ward, and the impact this had on Jayden's care and treatment. Ms Booroff, like many other family members and patient CPs, was and remains concerned by the number of bank/agency staff employed by Essex mental health services, their level of training, interviewing processes, and the high level of turnover of staff, all resulting in a distinct lack of consistency in care. Linked to this is also the recurring issue of staff being on leave, but having no cover in place, and patients and/or family members having to make do in their absence. When coupled with poor record keeping, communication, and information handover by staff, these concerns become starker and more troubling as the margins for mistakes and incompetency grow.

f. Failure to engage and involve Ms Booroff in decision making for Jayden's care and treatment. This is an issue repeatedly raised by family member CPs , and Ms Booroff echoes the sentiments raised in the opening statement of the charity INQUEST regarding this concern. Family members are valuable sources of information regarding their loved one's background and risk management. Ms Booroff's input into her son's care, and attempts to communicate further information pertinent to his care, treatment and risk assessment was routinely seen as interfering, irrelevant and even unhelpful. Staff missed significant opportunities to learn more about Jayden by communicating effectively with, and listening to, Ms Booroff.

g. A general yet frightening lack of compassion shown by staff towards Jayden and other patients. As detailed above, Jayden conveyed worrying stories and concerns about his time as an inpatient. The Channel 4 documentary, *Hospital Undercover Are They Safe? Dispatches*[1] brought to light the troubling and disturbing attitudes and actions of staff towards inpatients.

[1] https://www.channel4.com/programmes/hospital-undercover-are-they-safe-dispatches

h. Insecurity and inadequacy of the ward security and integrity. The entrance to the Linden Centre, a secure unit, had automatic doors opening to the community, through which Jayden was able to run when absconding from the ward. Jayden was able to follow a Healthcare Assistant through three locked doors, that could only be accessed by way of fob key. The ability for a detained patient to escape from a secure unit such as the Linden Centre, particularly when no s.17 leave has been granted, was of deep distress and concern to Ms Booroff.

i. Poor communication of the urgency and severity of Jayden's AWOL to emergency services. The Coroner's Inquest heard confused evidence between witnesses for EPUT and for Essex Police regarding sharing of communication, and professionals' ability to convey and understand the urgency and severity of the implications of a detained patient absconding from the ward. Jayden was not classified as being a high risk missing person after absconding by Essex Police.

j. Poor after-care by the Trust, and other services including Essex Police and British Transport Police, following Jayden's death. Ms Booroff remains under the care of EPUT, herself. She is experiencing long lasting and significant trauma, grief, and poor mental health as a result of the loss of her son, and the subsequent failings by EPUT to take accountability for that loss. Ms Booroff is expected to reach out to, trust, and rely upon the very service that she believes failed to keep her son safe. Moreover, she is expected to reach out to, trust, and rely upon the very service that delayed in its disclosure to the Coroner's Inquest, failed to implement the recommendations of the Patient Safety Incident Investigation report, and failed to learn from lessons before and after Jayden's death. Ms Booroff is not currently receiving care or treatment capable of meeting her needs. NHS care is the only option available to Ms Booroff. There has been no acknowledgment from the Trust of the impossible situation she has been placed in. There is no physician-patient relationship, and Ms Booroff has no faith at all in this Trust to be able to support her mental health.

19. Paragraph 42 of the Provisional List of Issues asks: *"How, and to what extent, were families, carers and / or other members of an inpatient's support network: a. informed of an inpatient's death; and / or b. communicated with during and after any internal investigations. What, if any, support was offered? Was this sufficient and appropriate in the circumstances?"* Ms Booroff has had insufficient and inappropriate support from EPUT since Jayden's death. Her inability to trust these mental health services is a huge and potentially insurmountable barrier to accessing support. Ms Booroff is eager for the Chair to consider this as part of the Inquiry investigation.

20. The above, and more, systemic issues were deeply ingrained in Trust culture by the time Jayden came to be cared for by EPUT, and contributed to his poor treatment. The lack of care and communication from doctors and ward staff demonstrated a troubling level of carelessness and complacency regarding Jayden's safety, during the most vulnerable moments of his short life.

21. Ms Booroff shares the concerns raised by other family members and patient CPs as outlined in their opening statements. It is clear that the very many issues concerning Essex mental health services are often complex, interconnected, and interdependent. This will require creative, thorough and fearless investigation by the Inquiry in order to bring to light these very real and ongoing concerns so that the system can be fixed.

22. Ms Booroff notes Section K of the Provisional List of Issues relates to the quality of investigations undertaken or commissioned by providers, and that the Chair will investigate how and what investigations were undertaken or commissioned by providers. Ms Booroff welcomes this approach. Ms Booroff also, however, has concerns about the Care Quality Commission's decision not to investigate Jayden's death due, according to the CQC, to there being no causal link between EPUT's failures and Jayden's death. Ms Booroff did not, and does not, agree with this decision and was disappointed at the CQC's refusal to investigate, particularly so soon after its damning unannounced inspection at Finchingfield ward in October 2020 resulting in the CQC serving a warning notice on EPUT[2]. Ms Booroff invites the Chair to consider such issues and decisions in this Inquiry.

D. Moving Forward

23. It would be impossible to count the number of times the phrase 'lessons learned' has been used by Essex mental health services. It has been said many times by witnesses in Coroner's Inquests, authors of Prevention of Future Death report responses, authors of Serious Incident Reports and Patient Safety Investigation Reports, and senior management at Essex mental health services to have come to have no meaning whatsoever. It is hard to see how any individual or family member let down by Essex mental health services could hear that phrase and believe it. Ms Booroff certainly has no faith or hope when she hears Essex mental health services talk about lessons learned. In fact, hearing them talk yet again about lessons they intend to learn, about failings they already knew about, causes her to feel triggered and gaslit.

24. Ms Booroff was legally represented in the Coroner's Inquest for Jayden. EPUT made no admissions of failings before, during, or after the Inquest evidence was heard. EPUT was poorly organised and poorly prepared for this Inquest. EPUT's delays in disclosure and decision-making plagued the Inquest process, culminating in the Trust's CEO being invited to a pre inquest review hearing to explain the Trust's poor decision-making that had threatened a last-minute adjournment of the Inquest.

25. During that Inquest significant, disturbing and serious failings were identified in the jury's narrative conclusion. A Prevention of Future Death Report was issued by the Coroner. Both have been referred to in Appendix 1 of the Opening Statement submitted on behalf of the patients and families represented by Hodge Jones & Allen solicitors. A Patient Safety Incident Investigation was commissioned by EPUT, the findings of which included numerous criticisms of the lack of care provided to Jayden. Despite this, EPUT failed to make admissions of failing and maintained a defensive approach at the Inquest. This process did little to assure Ms Booroff that lessons would indeed be learned.

26. Ms Booroff considers that the failings and ingrained systemic issues within Essex mental health services are apparent. The same issues, concerns, and failings arise time and time again in Coroner's Inquests, Prevention of Future Death reports, patient complaints, and internal incident

[2] CQC tells Essex Partnership University NHS Foundation Trust to make improvements at its inpatient mental health wards - Care Quality Commission

investigations. This endless repetition of tragic and traumatic outcomes due to systemic failings within Essex mental health services is alarming, distressing, and unacceptable.

27. An unwillingness to learn lessons from significant failings, a toxic culture of care, and a lack of accountability from senior management has led to Essex mental health services failing and continuing to fail their community. Had the Trusts learnt from numerous recommendations, investigations, serious incident reports, near misses, Coroner's Inquests and Prevention of Future Death Reports, Jayden may still be here today.

28. Ms Booroff currently has little to no faith that Essex mental health services will commit to recommendations made by the report. That will need to be earned and proven by the Trust CPs through the course of the Inquiry. The Chair and Inquiry will also have to grapple with the difficult question of ensuring compliance and cooperation, and what steps can be taken if that is not forthcoming.

29. We have had the benefit of reviewing the opening statement of family CPS and the charity INQUEST. Ms Booroff endorses those calls for action made by other CPs including:

    a. An approach by the Inquiry to obtain all potentially relevant material to determine what is and is not relevant to the Inquiry.

    b. For the Chair to keep an open mind regarding the need to publish interim recommendations.

    c. For the Chair to ensure that all recommendations are monitored and reviewed to ensure that those organisations tasked with implementing the recommendations do so and do so effectively. Ms Booroff endorses the suggestion that the Chair reviews this within a set period of time following publication of the Inquiry's report.

    d. INQUEST's call for the introduction of a National Oversight Mechanism.

    e. For the Chair to consider when and how criminal investigations may be required following an inpatient death in a mental health setting.

E. Conclusion

30. We close this statement with a plea to the Chair, and to all those participating in this Inquiry. That is a plea for transparency, honesty, and fearlessness in investigation. Ms Booroff's sincere hope is for her community to be served by an NHS Trust that holds their staff to account, and puts patients first. She hopes for an NHS Trust that has eradicated its toxic culture, including dangerous and outdated attitudes towards mental health conditions such as addiction. She hopes for an NHS Trust, that she can trust. All too well this community, and Ms Booroff, have seen that nothing changes, if nothing changes. A lot now needs to change to avoid any more preventable and avoidable deaths in mental health settings within Essex. Ms Booroff is putting her faith in this Inquiry to achieve that meaningful change. Ms Booroff trusts that the Chair will prioritise maintaining Jayden's dignity, and that of other patients, throughout the Inquiry.

31. We are grateful to the Chair for the detailed and wide reaching Terms of Reference and Provisional List of Issues determined for this Inquiry. Ms Booroff sincerely hopes that a result of this Inquiry is that no other family or individual will have to go through or endure what she, and so many others within Essex, have endured following engagement with Essex mental health services.

32. We look forward to working with the Inquiry on Ms Booroff's behalf.

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