IN THE LAMPARD INQUIRY

Witness Name: MICHELLE Booroff
Statement No: 1
Dated: 10 December 2025

FIRST WITNESS STATEMENT OF MICHELLE BOOROFF

I, Michelle Booroff, will say as follows:

1. I provide this statement in response to two requests from the Inquiry Legal Team under Rule 9 of the Inquiry Rules 2006 dated 24 February 2025 and 14 November 2025.

2. I exhibit to this statement a schedule of all the documentation that I possess in relation to Jayden's care under EPUT, in case any are considered of relevance to this Inquiry [**Exhibit MB1**]. These can be readily provided to the Inquiry, if and to the extent required.

Background

3. I am the mother of Jayden Booroff ("Jayden"), who was born in Chelmsford on 10 July 1997 and died on 23 October 2020, aged 23. Jayden had two younger half-siblings, who he loved dearly. He loved his role as the older, big brother and he always looked out for his siblings. Jayden also had two step-siblings who he was close with as well.

4. I provided an Opening Statement to the Inquiry during the commemorative hearings in November 2024, which included some background detail about who Jayden was. I also hope to provide a Commemorative and Impact Statement, at a later date, to the Inquiry.

5. Jayden was a happy baby. He reached all of his childhood milestones early. As soon as he could string a sentence together, he was singing. It was obvious that he loved singing from very early on. Jayden was a friendly and chatty child. He was very philosophical, even from a young age, and he would talk about dreams all the time. It was clear he was a deep thinker.

6. A lot of his childhood activities revolved around going to drama clubs, joining choirs and dancing classes, inside and outside of school. He was very agile and was part of the gymnastics team.

7. His main interests at secondary school were music and performing arts. Jayden received many achievement awards for his contribution to the Performing Arts Department and began to play the piano from around aged 13. Jayden came out about his sexuality when he was 15. We were all very proud of him for opening up to us. Unfortunately, he was bullied about his sexuality from junior school, through to high school. He did, though, find a great, kind group of friends to support him through these years.

8. Jayden and I had a very close bond. We would go on holidays together, make up and learn songs, sing them together, and generally spend lots of time together. I cherished this relationship then, and I still cherish it now.

9. Jayden was over the moon when he was accepted to the Arts Ed Performing Arts School in London, for a foundation course. I think this was in 2017. He was very excited to go there, after completing a 2-year course in Colchester Performing Arts College, and he had a wonderful year. He connected straightaway with his flatmates, all of whom he became very good friends with. He spent a year there and was disappointed when he did not get into the 3-year BA (Hons) degree course. He applied for other musical theatre courses and was accepted into Mountview College in London. Jayden was looking forward to doing more of what he loved. I remember being so proud and pleased by how independent and happy he was. Jayden was so passionate about continuing with a career in performing arts, he even took a night bus, on his own, to Scotland to audition for The Royal Conservatoire of Scotland.

10. I do not think Jayden enjoyed his course at Mountview College. He also struggled to make friends again, and I believe he began to struggle to cope. He was finding it difficult to survive on student finance alone, living in London, and he started gambling to try to make more money. This quickly turned into a gambling addiction. He also pawned his possessions, like his TV and Xbox, with the hope of getting them back eventually. I believe this all took a significant toll on his mental health. He also started to drink alcohol and smoke cannabis, as a way to cope with these new stresses. In 2017, aged 19, Jayden told me he wanted to leave Mountview College and to come home. I remember being shocked when I got to his flat to pick him up. Jayden had always taken pride in his appearance, but he looked very unkempt. His clothes were not washed, and he had not shaved or cut his hair. His room was very messy. I also noticed he had lost a significant amount of weight and looked gaunt. This was the first sign to me that he was becoming unwell.

11. Jayden returned to live at home with me and his two younger siblings in Chelmsford. I tried to get Jayden help with his gambling addiction and debts, through local charities and online support. He started to work at Tesco and then got a job as a waiter in several different restaurants. I think Jayden lost his way at this time (around 2017-2019). He had had big ambitions of doing musical theatre in London but had started to struggle with gambling and alcohol addictions, and he was struggling to find a career path.

12. Around this time Jayden also started to become more spiritual. He had always been spiritual, and a deep thinker, often wanting to discuss dreams about the 'big' subjects. But this started to develop into something else after he returned to live at home. Jayden was developing an interest in the 'law of attractions' and was increasingly thinking about other planes or realms. It seemed like he was losing touch with reality. He also began pulling away from friends and family, and started to suffer from switching between episodes of depression and anxiety, and then episodes of grandeur. Whilst Jayden's interest and fixation on leaving this realm to get to the next did begin to grow and increase,

he was not always fixated on this. At other times, he would strongly believe that it was impossible for him to die. This was just as concerning, as he sometimes developed a grandiose belief that he was invincible, and he could change the world. This gave him a deeply ingrained need to live. Jayden, and we as his family, had to adapt to his unpredictable changes between these different belief systems.

The Development of Jayden's Mental Ill-Health

13. I wish to start my statement by making clear that, when Jayden was well, he wanted to live. He had plans, ambitions, and dreams for his life. He wanted to perform, and to make art for the world. He wanted to answer life's big questions and find happiness. Jayden became very mentally unwell and would express feelings of not wanting to be here, and wanting to get to the next realm. But it is very important to me that anyone reading this statement understands that Jayden wanted to live. He sought help for his addictions and anxiety, he was trying methods of mindfulness such as journaling, and he wanted to move forward from his troubles.

14. In order to be able to answer some of the questions asked of me by the Inquiry, my legal team has reviewed and informed me of the content of a number of documents, including GP records, inpatient records, and material received during Jayden's inquest. I have also reviewed some of these records myself, but not in depth, due to the distressing impact of looking at such material. I will refer to these documents where relevant in order to best assist the Inquiry in providing as much information as possible about Jayden's involvement with Essex Partnership University NHS Foundation Trust ('EPUT'). Preparing this statement has been a long and painful process. Due to the significant trauma associated with writing this statement, and revisiting these events, sometimes I cannot remember exactly who I spoke to, or when specific incidents occurred. I have tried to be as specific as possible.

15. Jayden suffered from harm OCD from an early age. He also suffered from night terrors and night paralysis from a young age. As I have explained above, he was bullied at secondary school for his sexuality, which may have exacerbated the psychological difficulties he was already experiencing.

16. On 19 March 2019, Jayden and I attended A&E at Broomfield Hospital. My daughter had called an ambulance, but the police attended instead. When we attended A&E, Jayden was assessed by the Crisis Team. I think the police must have raised concerns about his presentation, leading to his being reviewed in A&E. I understand this was Jayden's first contact with mental health services. The accompanying notes from this contact record that Jayden asked for support in coping with his anxiety and OCD, reporting suffering from intrusive, worrying thoughts and stress. He asked to be started on an antidepressant or anti-anxiety medication. When he came out of his assessment, Jayden told me not to tell the hospital staff about any family history of mental ill-health. I think he said this because he was trying to minimise his symptoms. He was discharged home and was advised to contact his GP for a prescription of anti-depressant medication.

17. On 20 March 2019, social services contacted me by phone to follow up on the difficulties we, as a family, had faced the previous evening. I was offered a family support worker, **SW** who was allocated to me by Essex Social Services. She came to visit us a few times over the following months. I found her involvement helpful, albeit short-lived. She would provide me with strategies to try to help Jayden, and it also felt reassuring knowing that someone else was witnessing Jayden's escalating behaviours in this period. By this point, Jayden had begun taking illicit drugs, including cannabis, MDMA, and cocaine, and was drinking alcohol to self-medicate. We as a family were becoming increasingly worried about his welfare.

18. From early 2019, I noticed that Jayden had begun to make risky choices and was becoming increasingly susceptible to the influence of others.

19. On 20 June 2019, I discussed my concerns about Jayden's declining health with **SW** I had this conversation with her in front of Jayden which really upset him. I believed Jayden was losing touch with reality and becoming more paranoid. He did not always know who to trust and he did not like me discussing my concerns about him with professionals. I understand from the records that the family support worker in turn passed on my concerns to EPUT's Access and Assessment Team ('AAT'). The accompanying AAT entry records, amongst other concerns, that Jayden was talking in a grandiose manner about being a 'higher being', was running away and stating he was going to kill himself, and that he had been aggressive towards and threatened to stab me. Whilst the first few observations are accurate, Jayden had never threatened to stab me, and I do not understand where this came from; I believe it was a misunderstanding on behalf of the AAT. **SW** also passed on that Jayden was refusing to engage with Family Solutions or the GP. The notes record that the AAT nurse advised in response that I call emergency services if Jayden became aggressive and provided the number for an Approved Mental Health Professional ('AMHP'), however this was never discussed directly with me.

20. Sometime in June 2019, Jayden started to become very distressed. He was behaving very erratically and was saying things like he was going to kill himself. I became extremely worried for him, so I called the police. I did not know what else to do and was worried about what would happen if he ran off.

21. When the police arrived, I went into the police car to discuss my concerns with the officer, whilst Jayden remained in the kitchen speaking to another officer. Jayden's brother overhead Jayden saying that I was very unwell, and deflecting onto me, not acknowledging his own mental illness. I told one of the attending officers that I was really worried about Jayden. I reported that Jayden had been saying that he did not need to stay here, that he could not be here anymore, and that he wanted to kill himself. The officer I was speaking to appeared to have no understanding or compassion about my concerns. He said to me that Jayden was not going to kill himself, and those who said they would never do. He said "*basically, your son's a prick"* or words to that effect. The police officer then told me to leave Jayden in the garage for the night, and if I had any more trouble

they would come back out if we needed them. The police then left. I was left so shocked and confused by the officers' response.

22. Later that night, I called 999 again because Jayden began screaming and howling in the garage. He became aggressive and his behaviour continued to be very erratic and unpredictable. The operator who took the call could hear Jayden in the background and said to me '*he's not well is he*'. The operator agreed to send out the police again to the house. Jayden's brother was becoming upset with Jayden and they began to fight, pushing each other. As the police arrived, opening the door, Jayden kicked out and made contact with me. He did not hurt me or cause me any harm. I knew that Jayden was very unwell and was not in control of his actions at that point. The police officers however saw this incident and said they were concerned by Jayden's 'assault' of me.

23. The police took Jayden to the police station and he was later arrested. I was very upset by this as I knew that Jayden needed mental health help, not to be treated like a criminal. The police officers told me they were charging him with assault and battery and that I needed to confirm that he had assaulted me. They made me feel that if I did not agree to speak against Jayden, they would not be able to press charges, which they said was the only way to get him the mental health help he needed. I agreed that if I needed to, I would confirm that in court. I felt very uneasy about this; I just wanted Jayden to get the help he obviously needed. He did not need to be punished; he needed to be helped.

24. Jayden was subsequently charged with battery and assault. I will always feel guilty about this. On his release from the police station, he went to stay with my mum. When I saw him, I asked if he had had a mental health assessment when he was at the station. He told me that he had not. He said that the only question he was asked was whether he was going to try to hang himself with his hair tie (he had a ponytail at the time), which he denied. I knew that Jayden was going through an emotional breakdown or mental health crisis of some sort at this stage. However, instead of getting mental health help, he was arrested. Looking back, it is clear to me that the last place Jayden should have been was in police custody.

25. Following this incident, on 8 July 2019, Jayden had a GP consultation with Dr [I/S] who noted, in the accompanying clinical entry, that Jayden was stressed but denied depression. Jayden would often deny experiencing any feelings of anxiety, depression, or generally feeling unwell, and would often try to act like I was just being an overprotective or difficult mother. I believe he did this to try to avoid assessments and minimise the extent of his problems to medical professionals. Jayden also felt that mental health was stigmatised, and he would often say that he was worried about not being able to travel freely if he had a recorded history of poor mental health.

26. In a further consultation with Dr [I/S] on 13 July 2019, Jayden was recorded to report nausea and reduced appetite. His eyes were noted to look yellow. Dr [I/S] raised concerns about Jayden's liver and advised Jayden to cut down on his alcohol intake.

27. I recall that Jayden had to go to court in relation to the assault charge in around September 2019. At the time he was technically homeless. As his mother, I was not going to let him sleep on the streets, so I let him come back home. I knew however that I could not cope, and I was afraid I would not be able to keep him safe. My other children were also really struggling living with him due to his difficult and erratic behaviours. I told Jayden that he could live in the garage, attached to our house. It had a TV and a sofa in it and was usually a hangout space. Jayden preferred being in there to his bedroom as he wanted his own space. I would worry about him being in there as he would often lock the door from the inside, making it hard for me to check on him.

28. I recorded a video of Jayden in February 2020, in which he was talking about how he would be in a different spiritual place, and was saying very bizarre things. I recorded this to show his GP to try to get some form of mental health help for Jayden. I showed the video to his GP and asked them to help him, but they said he was an adult and so would need to come in on his own.

29. I believe that the summer of 2020, is when Jayden's mental health started to seriously decline. He began to show emerging signs of psychosis, and he began talking about going to the next realm.

[I/S]

30. On Jayden's birthday, on 10 July 2020, Jayden started to act very concerningly, saying that he needed to sacrifice himself in order to protect his family. He said that this was something he had to do, it was like he had no option, but he stated he was still scared. This was the first time he had spoken like this in front of our family, and I remember my mum being very confused and worried for him.

31. I recall another episode when Jayden and I had planned to watch a film together. That evening, I waited for him to come in from the garage. When he did not come, I knocked on the door to the garage but there was no answer, and the door was locked from the inside. I left it a few hours but still did not get any response from him. I called 999 in the early hours of the morning, and explained that Jayden was inside the garage, but I could not get in. I was worried that he had taken something and died. The fire brigade was called out. I had been asking for an ambulance, but because I could

not confirm if he was breathing or not, as I could not get into the garage, they sent the fire brigade instead. When the firefighters managed to gain entry to the garage, Jayden was not there, though he had left his wallet and phone behind. The firefighters told me to call the police, which I did. The police attended soon after. Jayden returned home later that morning, voluntarily. It was clear he had taken drugs. He said he had gone out, met some strangers and had taken drugs with them, but they had kicked him out. Because Jayden had said he had taken drugs, the police just treated the incident as if he had been on a binge or a bender. No referral was made for any mental health follow-up or support.

32. On 9 August 2020, according to the records, I called Essex Police again to raise concerns over Jayden's safety. He had left the house in a state of crisis, and I was concerned he was going to kill himself. He had already left the house like this several times that summer, including the episodes I have explained above. His brother and I would often go out looking for him. When I told this to the family support worker, she advised me to call the police if it happened again, for our safety and for Jayden's. I therefore called the police on this occasion. I told the police that Jayden had previously threatened to put rocks in his bag and drown himself, and that he had spoken about jumping in front of a train. Jayden had been saying things like this all summer. He would also often say statements along the lines of '[he] would not be here for much longer', or that '[he] would be going to the next realm soon'. Sometimes he would talk about the way in which he would do this, but not always. Essex Police informed British Transport Police ('BTP') in respect of Jayden's suicidal ideation about jumping in front of trains. I later found out at the inquest that BTP had accordingly put a marker on their systems, flagging train stations and tracks as a risk for Jayden. On this occasion, 9 August 2020, Jayden returned home voluntarily later that day.

33. On 4 September 2020, I called the police again to raise concerns that Jayden was having an acute psychotic episode. Jayden believed that he had to sacrifice himself to save his family. He believed if he did not sacrifice himself, his family would die or be killed. That morning, Jayden came into the house and asked me to hold his hands, asking if I could feel the energy. He was shaking and said he would have to leave this world. He looked very scared, and was acting quite childlike, needing lots of reassurance and comfort. He started to become panicked, explaining to me why he had to leave. He read out the text messages he had been exchanging with **[I/S]** **[I/S]** I became very worried that Jayden was going to take his own life. I believed that if I did not take action to stop him, Jayden would definitely follow through with this. It was not a threat; it was a definite decision by Jayden.

34. I left the room and messaged my friend, asking them to call the police to tell them that Jayden was really unwell and talking about ending his life. When the police arrived, Jayden became very panicked. I spoke to a police officer and showed them a video of Jayden discussing what I have described above, to show them just how unwell he was. Jayden was genuinely petrified to talk to the police. The police reassured him he was not in trouble, and that he needed to be open with

them. He was asking the police if they knew anything about local Satanic cults, and the police said that they could not discuss that with him. He was clearly very scared but was also very paranoid about the involvement of the police, especially given his previous contact with them and having been criminalised for his poor mental health rather than helped.

35. The police then said they wanted to speak to Jayden alone outside. I got the impression they felt that I was overreacting, or that this was just a family issue between myself and Jayden. When they spoke to Jayden outside, he began to downplay what had happened. He said that his relationship with me could be strained at times, and that I was overreacting. He also disclosed that he had taken drugs (I believe MDMA) the night before. I think because of this interaction, the police felt that Jayden was just presenting with a drug-related 'come down' rather than a genuine mental health crisis. I understand, from the relevant records, that the police also contacted the mental health street triage team to review Jayden over the phone. The corresponding triage note records that Jayden denied being suicidal or hearing any voices, stating that he felt that his mental health was fine and that I was overreacting. The review concluded that there were no apparent concerns over Jayden's mental health, though that it was difficult to establish over the phone whether or not he was being guarded. The police officers subsequently said there was nothing they could do, even though I had shown them direct evidence of Jayden's deeply concerning behaviour. I had tried to explain that Jayden had been unwell for a very long time and that he needed help. It was clear to me that he was experiencing some form of psychotic episode at this point. Despite this, neither the police nor the mental health services took any further steps to support Jayden or myself after this incident.

36. [I/S]

37. Shortly after this incident on 4 September 2020, I contacted Essex County Council social services asking for help for Jayden, as I did not know where else to turn. They called back later that day and spoke with me and my mum. My mum recalls them saying 'we're not interested in that, we're more interested in your 16-year-old daughter living at home with Jayden'. We explained that she was staying with her dad at the time, due to our concerns about being in the home with Jayden. It was very clear to us that they were more concerned about keeping my daughter safe, rather than offering support to Jayden and me to keep him safe.

38. Jayden desperately needed specialist mental health help by this point, but he was not getting any support whatsoever. As I have set out above, I had not had any success when I had previously tried to get help from the emergency services or the GP. On 16 September 2020, I received a letter from social services telling me that my request for support had not been taken further because they had not been able to make contact with me. I was not aware of having any missed calls from them, however things were so difficult caring for Jayden that I may not have answered calls from an unknown number. The letter was also sent in the context of concerns for my daughter's welfare and did not recognise any of the serious issues that Jayden was having. Social services did not offer any help or support for me or Jayden. This felt like another dead end.

39. Jayden had been living in the garage throughout this period, as I have explained above. It was in a very messy state. Jayden seemed to lose the ability to maintain his personal care over this time, in particular from the summer of 2020 onwards. Throughout 2020 I recall him presenting with more frequent suicidal ideation and becoming increasingly obsessed with ideas of moving to the next realm and sacrificing himself to protect our family. He was also displaying some risky behaviours at this time. Both his friends and family noted a concerning change in his personality. Around this time, I went to Jayden's workplace, as he was still working as a waiter, and asked to have a private word with his employer. He had worked for the restaurant previously, and I asked if they had noticed a change in Jayden, which they agreed they had. They said he was still lovely and sweet, but he was not the same Jayden as the year before. He was struggling with continued difficulties with gambling, drinking and substance misuse.

40. I had tried to get Jayden support with his addictions through local substance misuse services and charities, but none of these services were open to referrals due to the pandemic.

41. On 7 September 2020, I called Jayden's GP, Dr [I/S]. As I have already set out, I was very worried about Jayden's declining mental health by this point. I believed that he had become psychotic and that he may be suffering from schizophrenia. During this contact, I raised concerns with Dr [I/S] over Jayden's increasing suicidal thoughts and psychotic behaviours. I told Dr [I/S] that I felt Jayden needed to be sectioned. He was moving bizarrely, displaying extreme emotions, and seemed disconnected from reality. I explained my concerns to the GP that Jayden was displaying symptoms consistent with schizophrenia. Dr [I/S] told me that he would need to speak to Jayden directly, in order to directly assess his mental state before taking any further steps.

42. On that same day, I was also told to call the AMHP team due to Jayden's escalating presentation. I do not remember who advised me to do this, possibly it was social services. When I phoned the service, I was asked how I got their phone number and they told me that they could only accept a referral from a medical professional. I was making phone calls everywhere I possibly could, and I was going back and forth between so many different organisations, departments, and teams. I was desperate for someone to see how bad things had become for Jayden and to finally give him the

help he needed.

43. Jayden spoke to the GP, Dr [I/S], the following day, on 8 September 2020, in a telephone consultation. The accompanying record for this contact notes that Jayden disclosed suicidal ideation, and that he had been stockpiling medication. However, as far as I know, Jayden was not on any mental health medication at the time, so I am not sure what he could have been stockpiling. The GP made an urgent referral to the AAT for an assessment however, this did not take place until 10 September 2020. In the AAT referral letter, the GP recorded that Jayden "*regularly thinks of ending his life and admits he does have a stockpile of tablets at home which he would take*".

44. A Duty Nurse at the AAT tried to call Jayden several times on 9 September 2020, however I believe he had his phone turned off. They did not try to contact me, even though I was living with Jayden and caring for him, and the service was aware of the concerns I had raised about him.

45. On 10 September 2020, [I/S], an AAT practitioner, conducted a screening call with Jayden. It was mostly me on the phone, trying to get Jayden to engage with the call. The corresponding EPUT record reflects the concerns I raised during this call about Jayden's deteriorating behaviour over the past week. I reiterated that I was really worried about Jayden, as he was responding to unseen stimuli and he was talking about sacrificing himself for both him and his family. I felt strongly that what Jayden meant by this was that he needed to kill himself to protect his family, or to get to the next level of the universe he thought he was living in. I explained that I felt Jayden needed an urgent mental health assessment. Jayden also spoke with AAT, briefly. The clinical note records that Jayden reported hearing voices, felt out of control and was very scared as "*something was telling him to end his life*". The recorded outcome of this call was that Jayden required an urgent crisis assessment, with a referral to be made to the Crisis Team to review him as soon as possible. I do not know whether this referral was in fact made given that, as below, Jayden was not assessed by the Crisis Team over the coming days.

46. Shortly after this call, on 10 September 2020, Jayden ran away from home. Both the AAT practitioner and I called 999. I told the police that Jayden would go to the train station if he went missing, based on the previous comments he had made about jumping in front of a train. I do not believe that they made BTP aware of this. The police dispatched officers to attend my home, but they advised me that the mental health services would also need to intervene to support Jayden. The officers were on their way to my house when they saw Jayden walking home. They brought him home, reporting to me that Jayden seemed fine. The officers said that Jayden clearly needed a break from me, and vice versa, so they proposed taking Jayden to his friend's house. I was pleading with them that Jayden was not well. Jayden then said to me, in front of one of the officers, *"I told you I was going to go to the train tracks, but I changed my mind."* I asked if the officer heard that and they said they had, but that they were still going to take him to his friend's house, which they did. They did not appear at all concerned by what Jayden had said. I understand from the medical records that the AAT practitioner, [I/S], advised the police to either detain Jayden

under s.136 of the Mental Health Act 1983 ('MHA 1983') when found, or take him to A&E, due to the level of concern around his mental health. Notwithstanding this, the police did not seem at all concerned by Jayden's behaviour, taking no further action beyond dropping him off at his friend's house. Once again, I was left shocked, and in disbelief, at the police's limited response.

47. I also now know that earlier that same day, my mother had called the Trust's Community Mental Health Team ('CMHT') to raise her concerns about Jayden, reporting that she felt he was a risk to himself and others. As recorded in the clinical notes, she told the service that he had been acting bizarrely, acting out rituals in the garden and speaking about satanic beliefs, which we took as a clear indicator that he was in deepening crisis.

48. The following day, Friday 11 September 2020, I called the AAT again. I was becoming increasingly desperate about Jayden's worsening state. I pleaded with the team, telling them that Jayden had now been in psychotic crisis for 5 days, since Monday, and that no one was helping us. I told the AAT that I was concerned that Jayden had learnt how to mask the severity of his symptoms, and that when he spoke with professionals he knew what to say to get them to believe he was fine. The AAT professional told me they had been trying to contact Jayden, but they had not been able to speak with him. This was because his phone was turned off. It seemed they had no solution other than to just keep calling his phone. They told me they would try him again tomorrow and told me to call the Crisis Team or attend A&E if I had any concerns about his safety.

49. I believe Jayden also spoke to someone at AAT, that day, on 11 September 2020. I remember this was a man, though I have not seen a supporting entry for this contact in the contemporaneous notes. Jayden was very vulnerable and childlike that day, he seemed very confused. He was answering all of the screening questions as though he was me. I spoke to the AAT practitioner afterwards who agreed that it was clear Jayden was confused, and that he had realised Jayden was answering questions as though he was someone else. I remember feeling relieved that someone had finally understood Jayden was unwell, and that this may be the start of him getting proper psychiatric help.

50. I subsequently called the Crisis Team on 12 September 2020. I told them that Jayden was behaving very erratically and was difficult to de-escalate. I explained that the AAT was due to assess Jayden, and that I wanted it to be recorded that he was very unwell and behaving bizarrely. I did not want the AAT to just take Jayden at face value when he said he was fine, when he so clearly was not. The Crisis Team asked if they could speak to Jayden, but he refused to speak to them. The only advice the Crisis Team offered me was to call the police if Jayden became a risk to himself or others.

51. I called the Crisis Team again later that day as Jayden's presentation was escalating further, and I did not know where else to turn. I explained that Jayden was experiencing an acute psychotic episode, during which he shouted and became aggressive. He was not himself at all. Jayden did

not accept that he needed help and was getting upset with me for trying to get him to recognise his behaviours. He was becoming really paranoid, presenting with increasingly delusional and intrusive thoughts. While I was on the phone to the Crisis Team, relaying these concerns, I was also speaking to Jayden in the background, trying to reassure him and to persuade him to get some sleep. Once again, all the Crisis Team did was tell me to call 999 if Jayden became a danger to himself or others. I felt so hopeless and frustrated.

52. Around 1pm that day, I once more called the AAT to try to get them to speak to Jayden urgently. The corresponding record of this call notes that: "*Jayden reported that recently he has been in his own world and his mood would go from calm to paranoid and manic and then will have emotional breakdown, 'it's sort of too much and it's really unfair"*. I believe this is in fact information I relayed to the AAT. The same entry records that the triage call was difficult to conduct with Jayden as he "*kept veering off topics",* talking about his connections with the universe. It is recorded that Jayden reported fleeting suicidal ideation, disclosing that he had made several past attempts but would not explain further. He stated that he just wanted to talk to someone. The recorded plan was for Jayden to be assessed by the AAT the following day.

53. Shortly after this phone contact, Jayden ran away from home, going through a fence in the back garden. I reported this to the police and told them that Jayden was having a mental health crisis. I understand that Essex Police in turn informed the BTP of this. The police COMPACT log records that Jayden was a suicide risk and had recently made suicidal comments, including about filling a bag with bricks and jumping into the river, and that his preferred 'method' would be to jump in front of a train. The log also noted that Jayden was a regular cannabis user.

54. At around 3pm, the AAT called me to try to reschedule the time for Jayden's appointment the following day. I told them it was too late, and that Jayden had run away about an hour ago. I was very upset at this point as I felt as though I had been pleading and begging for help for so long and nothing had happened. The corresponding clinical record from this contact records that I said that I had been "*screaming for help the past week"*. I repeated to the AAT, the police, and the AMHP, whom I later spoke to, that I was worried that Jayden was going to kill himself by jumping in front of a train. The AAT practitioner I spoke to suggested that when Jayden was found I should ask the police to either detain him under s.136 of the MHA 1983 or to take him to A&E for a mental health assessment, if they felt that the s.136 threshold was not met.

55. The police came to my house and asked me for a photo of Jayden. We asked his friends to text him asking to meet up. I also managed to speak to Jayden on the phone and could hear leaves rustling in the background. During the call, Jayden kept changing his mind saying he would and then he would not come home. He seemed to be switching between states of mind.

56. The police had also texted Jayden to tell him they were looking for him. Before they began any search for Jayden, he returned home later that evening on his own. I tried to find out where he had

been, but he just said he had gone wandering.

57. When Jayden arrived home, I was on the phone with someone at the AAT. The practitioner could hear the police talking to Jayden in the background. I felt that the AAT practitioner was getting increasingly annoyed with the way the police were interacting with Jayden as they clearly did not believe he was at risk to himself. The AAT practitioner asked to speak to the police officers, and I handed over the phone. She told the officers that they needed to get Jayden to the A&E urgently, and for me to go with him to support him and make sure he did not run away. Up until then, the police had been repeatedly telling Jayden that he did not have to go to hospital if he did not want to. One police officer also repeatedly told him that he did not need me there if he did not want me. I had the distinct impression that she felt I was being an overbearing, overprotective mother. Jayden said he wanted me there. The police eventually agreed to bring us to the A&E at Broomfield Hospital, after speaking to the AAT practitioner.

58. At A&E, a clinician came to speak to Jayden in the waiting area. Jayden was acting very strangely, answering questions as if he was someone else, rather than himself. He was clearly confused about his identity, however, was answering questions in a calm, confident way, masking how unwell he was. Jayden was then assessed in a joint assessment by the A&E Psychiatric Liaison Team and the Trust's 'gatekeeping' team. Jayden first went in for an assessment on his own; I then joined him and stayed on to speak to the assessors separately. I asked to speak to them alone because they were talking about home treatment, and I felt I needed to make clear to them that Jayden was masking how deeply unwell he was and needed to be admitted to hospital. I also expressly stated that I needed support and help to protect Jayden.

59. The clinical entry concerning Jayden's initial assessment records that he denied any suicidal ideation and reported leaving the house to get some 'chill out' time away from home. This was a common theme with Jayden, where he would try to blame me and his family, and attribute his behaviours to a stressful home life, meaning he just sometimes needed some quiet time. I believe this is very typical behaviour of someone with psychosis, and I would have thought that mental health professionals could recognise this deflective behaviour as part of the pattern of psychosis. I strongly felt that Jayden was masking and knew he could persuade mental health professionals by putting on a front. Jayden did not know how ill he was or how urgently he needed help. I also strongly felt that the Trust practitioners assessing him knew that Jayden was very unwell, but sought to rely on the generalised concept of patient autonomy to justify discharging him. I had a distinct impression that they did not want to admit him, on the basis of resources, rather than because they did not think he met the criteria.

60. When I saw the mental health practitioners independently, I pressed upon them my concerns over how unwell Jayden was and how he was masking how he was really feeling. I told them how much Jayden had changed over the past year, and described some of the bizarre behaviours he had started to exhibit recently, for example 'exorcising' the house, communicating with the universe, and speaking to his imaginary friend. I showed them the video I had recorded of Jayden earlier

that week having a psychotic episode (which I also showed to the police, as I have explained above). I explained that I was exhausted from caring for Jayden, and that I could not continue. I told them I was scared that Jayden was going to try to kill himself by jumping in front of a train, or by some other way, and explained that we had a family history of schizophrenia. I reiterated that Jayden desperately needed help and asked for him to be sectioned, or even just taken into hospital for a short while to afford us both some respite. I recall that I told the practitioners that Jayden had been saying all week that he only had a few days left, and that life would be better if it ended. The information that I handed over is also summarised in the corresponding clinical record for this contact.

61. However, despite the serious concerns I raised, the A&E Psychiatric Liaison Team and Trust's 'gatekeeping' team declined to admit Jayden as an inpatient, instead referring him to the Home First Treatment team ('HFT') for a period of community treatment. The related clinical entry notes that Jayden did not appear in crisis, however that he was possibly self-medicating with alcohol and illicit substances which may be a contributory factor to his declining mental state. The recorded plan was for Jayden to be seen daily by the HFT and to be seen by the psychiatrist in two days' time (i.e. the following Monday). There seemed to be no recognition that Jayden lacked insight into his needs and risks, and therefore that community treatment would be very limited in its ability to treat his underlying condition. I could not understand how the hospital was discharging Jayden after I had pleaded for him to be admitted, and raised my express concerns that he was going to try and kill himself.

62. I was so disappointed by the decision not to admit Jayden and to send him back to my care. I felt completely exhausted. I knew I could not continue to care for Jayden at home like I had been doing, and I was extremely worried about what he might do if I was not able to keep an eye on him all the time. I asked the Psychiatric Liaison Team what to do if Jayden left the house. Again, the only solution I was given was to call the police. Before leaving the hospital, Jayden was given 2mg of Lorazepam, the Crisis line contact details, and a Mental Health Liaison information leaflet. I did not understand what good this information would do for Jayden when he was not in a fit state to understand what was happening to him, far less how he could seek help. The only reason Jayden was given Lorazepam was to sedate him, so that I could get some sleep, but this did not work. I was not given any written discharge or crisis plan to help me in managing Jayden's risk in the community. I believe that Jayden was contacted by a member by of the HFT later that evening, after he was discharged home.

63. The next day, 13 September 2020, Jayden was seen at home by the HFT. Whilst Jayden tried to reassure the HFT nurse that he was fine, I told them that he was not being honest with them about his mental health or showing his real self. I note from the clinical records that his 'RAG' rating was assessed as red at this stage due to his impulsivity. The HFT staff were concerned by Jayden's presentation and so booked him for an assessment with the outpatient psychiatrist at the Linden

Centre the following day. As recorded in the EPUT records, my mum also called the HFT that day to report her concerns that Jayden was "*seriously, seriously, seriously unwell*" and that he would try and "*say the right things*" to staff to avoid being taken to hospital. We were all so worried that the mental health staff would continue to believe Jayden and would not see how unwell he was, meaning we would be left alone to care for him once again and the cycle would continue.

64. During this meeting, the HFT nurse discussed with me that Jayden should start antipsychotic medication. I asked how this would be monitored, as I was really concerned about Jayden's reaction to this kind of medication, and about ensuring that he took it regularly and at the right times. The HFT nurse told me that, as I would be caring for Jayden, I would be responsible for monitoring his compliance. No additional support or resources about how to do this was offered to me. This felt very worrying and dangerous to me. These medications were not prescribed at this time.

65. Also during this meeting, I asked the HFT nurse what to do if Jayden wanted to go out, and I was told that I could not stop him. I said this was why I wanted him to be sectioned because I could not keep him safe. That evening, Jayden went out for a walk. He then called me and said he was going to meet someone he met online. He said to me "*If I die, just know the address*". I asked for the address, which turned out to be near the railway station. We had several phone calls because Jayden kept hanging up the phone. He would call me and say it was too dangerous and he should not go through with it, before calling again and saying he was going to go. He was switching back and forth between recognising and minimising the risk he was placing himself in. I was really worried for his safety, and tried repeatedly to persuade him to come home. I was trying to keep him calm and grounded, to show him why this was a dangerous situation. About half an hour later, Jayden called me again saying he was being set up and people were trying to kill him. I asked where he was and he confirmed he was near the railway station. On my approach to the address, I saw Jayden running down the road. He got into the car and was clearly petrified. He said that he could see a group of men, with guns in a bag, outside the car, though I could not see anyone. He repeated that someone was setting him up to kill him. I felt relieved that I had Jayden in the car with me and that he was safe, though it was clear to me he was seriously unwell. As we got close to the house, he pulled out a bag of MDMA pills. I asked if he had taken any, and he said he had taken one. He said he was going to take them all to sacrifice himself. I asked him to give me the bag, which he did. He was acting very bizarrely and erratically, in a way in which I had never seen him before when he had previously been psychotic, which I believe was the additional impact of the MDMA. I had to look up on online to ask how to look after someone on MDMA, as I had no other support.

66. When we got home I did not know what to do, as I was so worried for Jayden's safety, as well as for my other son, who was upstairs. I called the Crisis Team number and explained what had happened. They kept asking me if I was in any danger, as if to say if there was no immediate danger of a physical nature, why was I calling them. I eventually told them Jayden had picked up

a knife at me. He had not, he was not acting aggressively at all, but I felt that I needed to say something more extreme to get them to take me seriously, as they had not been listening to me up to this point. I was desperate for help. Because of this, the Crisis Team contacted the police to attend. Jayden was so confused and scared when the police arrived. He thought they were there in respect of his own 'attempted murder', so he was explaining to them about the men he had seen earlier with guns. Some of the police officers in attendance were understanding of Jayden's clear illness, whilst others were less so.

67. The police left but called an ambulance for Jayden. A paramedic subsequently attended and assessed Jayden, taking his vitals and an ECG. The paramedic advised that Jayden was at risk of heart failure and that he should go to hospital because his results were so concerning. Jayden refused to go. I really wanted him to go to hospital and asked the paramedic whether they could take him. I told the paramedic that Jayden was meant to be going into hospital for a mental health assessment the next day, with a view to being potentially detained, to emphasise just how unwell Jayden was. The paramedic said that he could not do anything to force Jayden to attend hospital and told me instead to lock myself and my other son in my room. I locked all the doors and windows in the house that night. I did not sleep at all; I was so scared that Jayden would die in the night. Jayden did not sleep the whole night. He was up, pacing around the house and, bashing the keys on the piano, erratically.

68. The next day, 14 September 2020, I took Jayden to the Linden Centre for his psychiatrist appointment. He was assessed by Dr G a Consultant Psychiatrist, who advised that Jayden should be admitted as an inpatient under section 2 of the MHA 1983. I note that Dr G subsequent medical recommendation recorded that Jayden presented as "*very thought disordered"* and "*extremely vulnerable"* and lacked capacity to consent to an informal admission. Dr G however explained to me that, due to Covid restrictions, Jayden would need to wait off premises whilst the AMHP and second approved s.12 doctor's assessments were organised. I was very worried about leaving the Linden Centre with Jayden, as I was concerned that he was going to run away again. I just wanted to keep him safe until he could be admitted to hospital. I asked Dr G what I should do if Jayden ran away. He just said to call the police. He was aware there was a very high risk of Jayden running away, but there was nothing else he could offer in light of the Covid restrictions. We went back to my mum's house in the interim to wait for the AMHP to confirm the assessment.

69. We waited for several hours, but had not heard anything more about when the further assessments would be. I therefore called the Linden Centre to check how long it would be until we could bring Jayden back in for the next assessments. I told them that Jayden was becoming increasingly paranoid and anxious to leave. He thought I was a robot and did not believe I was real. He had also already tried to leave the house several times and, whilst I had managed to convince him to stay, I was struggling to keep him there. As I was on the phone, my mum shouted *"he's gone, he's jumped over the fence"*, as Jayden had just escaped through the garden. The staff member on the

phone told me to call the police, which I did. I think the Linden Centre also called the police. I was so worried and told the staff member I was speaking to that if anything happened to Jayden, it would be the fault of the Linden Centre. I was so scared that Jayden may be found dead, by the time the police started searching, and was angry that we had been made to leave the Linden Centre when he was so clearly unwell.

70. I then went out to look for Jayden in the car. As I was driving down the main road in Broomfield, I saw Jayden. I was on the phone to the police at the time, and lost sight of him after he ran down an alleyway. I got out of the car and started searching for him. I ran across a busy road whilst on the phone, and I remember the police advising me to keep myself safe. I was so desperate to keep Jayden safe I had begun putting myself in danger. I hung up on the police, after telling them where I believed he was heading towards, as I needed to run after Jayden.

71. I lost sight of Jayden and eventually I had to go back to my mum's house as she had become hysterical with worry. I was also deeply affected by what was happening, and had begun to have a very strong feeling that Jayden had died. I told my mum, and she became very concerned for me, and called the Crisis Team.

72. I cannot remember when, but eventually the police called my mum. We were both worried they were calling to tell us Jayden had died. I was very worried about what the paramedic had told us about Jayden being at risk of heart failure, as well as him being extremely vulnerable and unwell. It was also a very hot day. I was worried for his physical, as well as his mental, health. The police told us that they had found Jayden, and we were shocked and relieved they had found him alive.

73. At Jayden's inquest I learnt that the police found Jayden and took him back to my house, but he did not have his keys to get inside and I was not back yet from searching for him. He was checked by the paramedics outside and reportedly disclosed having taken MDMA at 11pm the previous night. Jayden tried to persuade the police that he was fine, which the officers seemed willing to accept. Dr G however managed to speak to the officers over the phone and explained that Jayden was very unwell and required psychiatric assessment in hospital. I understand that Dr G had to push very hard to convince the police to use their powers to detain Jayden. It seemed like a battle for Dr G to get them to understand how unwell Jayden was. Dr G confirmed Jayden was presenting as actively psychotic at the time and a risk to himself and possibly others. The police consequently detained Jayden, outside my house, under s.136 of the MHA 1983, and brought him to the Linden Centre for an assessment for inpatient admission.

74. I am very concerned that the police brought Jayden back to my home, when they knew he had been waiting with us at his grandmother's home to be assessed for detention. I am also very concerned that it is only by chance that Jayden came to be detained by the police. If he had his keys, then he would have been able to go inside and it would have been far more difficult for the police to bring him to the Linden Centre.

75. Jayden was taken to the Christopher Unit at the Linden Centre. I recall there was quite a lot of confusion about where Jayden was, as I was not with him when he had been admitted, and it was really difficult to get hold of the right phone numbers to find out where he was.

76. Early on 15 September 2020, Jayden underwent a Mental Health Act assessment. Having already been assessed by **Dr G** the day before, Jayden was assessed by the second s.12 approved psychiatrist, Dr **[I/S]**, as well as by an AMHP from Essex County Council **[I/S]** **[I/S]**. It was noted during these assessments that Jayden was expressing suicidal ideation and had been responding to unseen stimuli. He was considered to likely be suffering from a psychotic episode. I felt that the assessing clinicians took into consideration, and gave weight to, the information we shared, including the alarming change in his personality and increased use of drugs and alcohol. I remember having a phone call with the AMHP, **[I/S]** for her to obtain further information about Jayden. They then called me back to confirm that Jayden would be detained. I was so relieved that he was finally getting the help and protection he needed.

77. Jayden was subsequently assessed as requiring detention under s.2 of the MHA 1983.

78. I attended the Christopher Unit to drop off some of Jayden's belongings. A member of staff came to collect his belongings, and I asked her how Jayden had received the news that he was being detained. The staff member laughed a bit, saying that he did resist a little bit and they almost had to restrain him, but that in the end he accepted it. She also said she did not know much about how this process worked, as she was covering this unit because they were short staffed. I was mostly just relieved that Jayden was finally safe. Looking back, however, I find her casual approach to a concerned relative alarming.

The Lakes Admission: 15 - 28 September 2020

79. Jayden was admitted under s.2 of the MHA 1983 to Gosfield Ward, at The Lakes Mental Health Hospital, from 15 to 28 September 2020. I do not know the reason or circumstances for his transfer from the Christopher Unit at the Linden Centre to Gosfield Ward at The Lakes. Jayden was detained for 14 days in total. I was so relieved by this admission as I hoped that, finally, Jayden would get the mental health care and treatment he so urgently needed.

80. When Jayden arrived on the ward he was nursed in isolation, due to Covid restrictions. He needed to wait for a negative Covid-19 test before he could come out of isolation. I understand, from the inpatient records, that during this period he was being nursed on Level 2 observations, meaning he was supposed to be checked by staff four times per hour.

81. I felt entirely shut out from Jayden's care whilst he was an inpatient at The Lakes. Despite my repeated attempts to engage with the ward staff about Jayden's ongoing psychotic symptoms,

they did not take my concerns seriously or seek my insight, despite my knowing him better than anyone. When he first arrived at The Lakes, Jayden did not have his phone with him. I therefore had no way of contacting him, other than via the main ward phone. When I raised this initially with a member of staff, they told me it might be a good idea to not bring Jayden's phone in for a few days. They did not explain why. Knowing what I now know (that I was not invited to the first two ward meetings and staff told Jayden he did not need me there), I wonder if this was an attempt by the ward staff to stop or minimise the amount of contact I had with Jayden whilst he was on the ward.

82. I was told not to visit for the first few days, so as to let Jayden settle in. It was really difficult to find a contact number for the ward in the first place, in order to call to check in on Jayden and provide staff with relevant background information about him. I recall at one point early on during Jayden's admission, the number I had for the ward was disconnected and no longer worked. I had to call around to find the new number. No one gave this to me in advance, or warned me that the number would be changing. Jayden did not have an allocated member of staff to coordinate or keywork his care, in so far as I was aware, so when I did manage to speak to the ward I would often speak to different members of staff each time. I could never therefore be assured that the concerns I was raising were being properly actioned and escalated across the ward team.

83. I brought Jayden's phone in for him on or around 24 September 2020. We then began messaging and calling directly. When I did start to hear from him directly by phone, he did seem a little calmer, which I believe was the effect of the daily Lorazepam and Promethazine PRN medication he had been started on. I was however very worried that he was masking the true extent of his symptoms to staff and lulling them into a false sense of security that he was fine. This appears to have in fact been the case, from the inpatient records my solicitors have since reviewed, which indicate that staff seemed to accept at face value Jayden's assurances that he was not mentally unwell, and that his admission was just a result of external stressors in his life. Jayden would often tell the ward staff that we had a difficult relationship, and that I was overprotective, which was why he was in hospital. I believe that, from his various police and mental health interactions in the community, he had realised that blaming our relationship was a good way to deflect from his real issues. He saw this as an effective way for him to mask, and staff either did not appear able to see past this or chose to use this as a 'get out' to avoid treating the mental health problems Jayden was facing. I believe staff even encouraged the extent of Jayden's masking, to make their jobs easier. Jayden was clever, and he had picked up on key words and phrases that staff wanted to hear, such as 'I'm fine', or 'I just needed a break from my mum'. Jayden was also open about his drug and alcohol addictions, which I believe staff saw as something they were not responsible for treating and could use as a way of avoiding responsibility.

84. I believed Jayden was deflecting from his mental health problems, because he truly believed he did not have any. I also felt that the staff on Gosfield Ward were disregarding his drug and alcohol problems, and treating them as though they were voluntary and Jayden was to blame. If they had

listened to me and sought my views, rather than dismissing me as the overbearing mother, they would have appreciated that Jayden's drug and alcohol use was a direct consequence, rather than cause, of his mental health problems.

85. I note also that there are various references in the inpatient records to Jayden denying that he was suicidal, stating he had only said this to 'provoke' me. This was simply not true. In the weeks before his admission, as I have set out above, Jayden had been presenting with escalating suicidal ideation with specific intent. This, coupled with his increasingly bizarre and delusional behaviours, left no doubt in my mind that Jayden genuinely meant what he said when he spoke about ending his life. Again, if I had been consulted about this, I would have made clear that Jayden was just trying to minimise and distract from how unwell he really was as he wanted to be discharged. Moreover, I strongly feel that Jayden had even picked up on the word 'provoke' from staff. I do not believe he would have used this word of his own accord and he again learnt to say this to go along with staff's narrative. Leaving hospital was always Jayden's main goal whilst he was an inpatient.

86. A few days into Jayden's admission, on 17 September 2020, I called the ward as no one had yet contacted me to update me on his progress. As noted in the inpatient records, I directly raised my concerns that Jayden was trying to convince staff that he was not unwell, and was trying to blame me for his detention. I expressly asked to be involved in the discharge planning process concerning Jayden from the outset. The records reflect that I told staff that Jayden had bought the drugs that were found on him on 14 September 2020 with the intention of overdosing on them. Actually, what I had tried to convey was that Jayden wanted to take these drugs to get to the next realm.

87. From the records I understand that the following day, 18 September 2020, I was contacted by a trainee doctor who informed me that, whilst he could not share any information with me concerning Jayden's treatment, as he did not consent to this, I was able to share information with him. This was very unlike Jayden; he had always relied on me and wanted me there to support him. I feel that he was influenced by staff to shut me out. I felt that the clinical team simply accepted without challenge Jayden's statements that I was the reason he was detained, without exploring this against the contextual information known about the reasons for his admission and his acute presentation. I provided the trainee doctor with a detailed handover about Jayden, explaining his deterioration over the past year, with increased drug misuse and suicidality, and my ongoing concerns for his psychotic state. I stressed that I could not have Jayden back home to live with me. From review of the inpatient records, it does not appear that my concerns were escalated or explored with Jayden.

88. I cannot remember the exact date, but at some point during his admission Jayden's best friend and I went to visit him in The Lakes. Jayden was brought into reception by a member of staff, possibly a healthcare assistant, called [I/S]. I remember being very concerned that Jayden was

being offered leave at the time and I was worried about him running off. I told [I/S] that Jayden had a history of absconding, which he did not know about. I was very worried that he did not now about this as it was a very important part of Jayden's history. I asked that he made sure that everyone on the ward was aware of his absconding risks. Jayden's friend and I took Jayden out of the ward to the café in the main hospital. Jayden was acting very bizarrely, leaving the drink he bought at the check out, and talking about having his mind read. He also said that he did not want to tell staff about this as they would keep him in hospital for longer if they knew about this. He asked me to keep it a secret.

89. When we got back to the hospital, I asked to speak to someone to pass on what Jayden had said. I spoke to a staff member and asked for this to be made clear in his notes, however I can see no corresponding entry of this contact in the inpatient records.

90. By 21 September 2020, the inpatient records note that Jayden was being nursed on Level 1 observations.

91. On 21 September 2020, I was invited to attend Jayden's ward review. While I waited in the reception, I was given a feedback form to fill out. This form was asking me about my experience with the service, which I felt would be more appropriate to complete once Jayden had been discharged. I did not want to put anything negative about Jayden's treatment and care, in case that impacted how Jayden's was looked after the rest of his admission. I did, however, mention the fact that the phone lines had changed and how concerning this had been when I had been trying to contact the ward.

92. Jayden's Responsible Clinician, Dr B attended the ward round, alongside various other clinical professionals and Jayden. From the records, I understand that whilst this was the first ward review that I attended, it was in fact the third review since Jayden's admission. I cannot understand why my involvement was not sought at these earlier reviews, given that I had better insight into Jayden's circumstances than anyone. During this review, I sought to hand over important background information about Jayden to the ward team in advance of him joining the meeting. This largely reflected what I had conveyed to staff over the phone in the days before, but I felt it was necessary to emphasise this in person given how serious my concerns were. I summarised Jayden's recent delusional and high-risk behaviours, and even showed the ward team videos from Jayden's recent psychotic episodes. However, I did not feel listened to during this meeting, and I felt rushed. The accompanying risk assessment for this ward review records that I was "*distressed and worried that* [Jayden's] *current presentation would be a precursor to suicidal behaviours*". I certainly remember relaying how concerned I was for his safety, and that he had been saying he was suicidal. I also, again, repeated that I could not have Jayden back to live with me on discharge, as I needed to protect my other children, and that I was worried he would abscond if he was given leave from the ward.

93. Jayden was then invited to join the meeting. He denied the concerns I had raised and stated he

wanted to be discharged. He was asked by the ward team whether he hallucinated seeing Jesus. He replied "*isn't Jesus always around us?*", to which I noted some of the staff present at the meeting nodding along. It was clear to me that the ward staff interpreted Jayden's bizarre ideation as expressions of Christianity, and did not see that these were delusional beliefs about other realms which, in the context of his other behaviours, were plainly psychotic.

94. The records reflect that the ward team subsequently decided to offer Jayden s.17 escorted leave, despite my expressed concerns, and to start the discharge planning process. I was very concerned that he was being offered leave, and reiterated that he was at high risk of absconding. Jayden didn't like me saying this to staff, however I was really worried that he was masking and possibly planning to run off.

95. During this ward review, the ward team told me that Jayden was going to be given psychotherapy, support with his addictions and his housing situation, and other treatment. I have not since seen any evidence in the records of this. I also have not seen any evidence to indicate that discharge planning was begun, other than saying it would begin in this ward review.

96. I was very concerned that Jayden was being offered leave, which I believed was limited to having cigarette breaks in the garden. I remember coming away from this meeting thinking that at least Jayden was going to be offered the psychological intervention he needed and that he would be staying in hospital for a while.

97. On or around 27 September 2020, Jayden was messaging me saying that he did not want to be on the ward anymore and he referred to another patient making rude, sexualised gestures towards him, whom he was scared would rape him. He said that he had told the night staff but that they did not care, and they just watched fights break out without intervening. Jayden said that he did not feel safe on the ward.

98. By this point, Jayden appeared to have understood that he was going to be detained in hospital for a while, so he began to tell me about his plans to escape the next day.

99. After exchanging these messages, I called the Crisis Team to seek support for myself. I was feeling very confused about what Jayden was saying in his text messages, and did not know if he was trying to manipulate me to help him get out of the ward or if what he was reporting to me about other patients and staff was true. Instead of supporting me, the Crisis Team put me through to Gosfield Ward to discuss Jayden with them. I then raised with the ward staff that I was going to come to visit Jayden the next day at 12:30pm, and he had told me of his plans to escape the next day. I asked the staff not to grant him leave before I arrived as he would try to abscond.

100. I attended The Lakes again on 28 September 2020, on the understanding that I would be attending a ward round to discuss Jayden's continued treatment plan in hospital. I believe that I called the ward again, that morning, further to my call the previous night, on my way into the

hospital. I called again as I remembered the night staff being very blasé about my call, and I really wanted to warn staff not to grant Jayden s.17 leave as I was terrified that he would abscond. I asked staff not to let Jayden know I had called, as I was worried he would continue to suggest I was being the overprotective mother and minimise the extent of his problems. I expressly asked that Jayden not be granted leave until I arrived, as he had said he would try to escape. I understand he was granted unescorted leave regardless that morning. Jayden told me that staff had offered him leave, saying that if he could go out for a cigarette break and then come back onto the ward this would demonstrate to them that he could keep himself safe, and so he could then be discharged. This felt to me like they were bargaining with and manipulating him.

101. I note from the inpatient records that, after returning from his leave, Jayden had a 1:1 session with psychiatrist **Dr J** before the ward review, in which it was recorded that Jayden showed" insight" around his spirituality which appeared to be "*over valued beliefs but not delusional*".

102. When I arrived at The Lakes, I attended the ward review with Dr **B**, Dr **J**, Dr **[I/S]**, CPN **[I/S]**, and Jayden. Having this number of professionals present at the meeting felt very intimidating and overpowering. I was told I could not have anyone with me for support, which I believe was for Covid restriction reasons. It felt like I was on my own, against all of these professionals who had already made their minds up about Jayden's mental health. I also felt that they had misconceived preconceptions about me, my mental health, and my spirituality.

103. During this meeting, I was informed that a decision had been made that Jayden would be discharged later that day. I was extremely concerned by this decision, especially given the concerns I had sought to repeatedly raise about Jayden's condition throughout his admission. I was so shocked. It was apparent to me that Jayden was still very unwell. I could not understand how he could be safely discharged, so early into his admission, without having received any form of psychological treatment, and having shown no material signs of improvement or reduction in risk. I had been given no warning of this discharge. I showed the ward team a letter my mother had written about how unwell Jayden was. I also tried to show them a video of Jayden's best friend, saying how unwell he was and how important it was that he stayed in hospital. She had not been allowed to come to this meeting, and so had made the video to put her views forward. The ward team did not watch this video, dismissed these concerns, and began calling Jayden into the room. We were all so desperate for Jayden to remain in hospital, where we had believed he would be protected and get the treatment he required. Looking back, I strongly believe that Jayden was being discharged at this point, further to my phone calls about his high risk of absconding, because they did not want to assume the risk of another patient absconding, and possibly taking their life, under their watch.

104. In this meeting, I was also told by Jayden's clinical team that no material concerns had been raised during the admission over his presentation, and that he did not suffer from a mental illness that required detention. The team attributed drug and alcohol abuse as the cause for his admission, rather than psychosis or potential schizophrenia. The clinical record of this review

notes Jayden presenting with "*possible Schizotypal Personality trait",* with the accompanying 'cluster assessment' recording "*severe to very severe"* substance misuse issues. For the reasons I have already sought to explain above, I do not agree with the assessment that Jayden did not have a severe mental illness. In my view Jayden was suffering from a psychotic illness, characterised by increasingly delusional and suicidal ideation, which required significant psychiatric support.

105. I explained to the ward team, in plain terms, that I could not bring Jayden home. As I had already raised with ward staff on numerous previous occasions, I made clear I could not care for him at home as it was not safe for him or my other children. In response, I was simply given a 'supporting letter' to give to the Council that I was told would support Jayden in getting accommodation when discharged. It was just assumed that Jayden would come home with me, and we would sort his accommodation out then, after he was discharged. No one recognised that, technically, Jayden was homeless because I was not willing for him to live with me. Of course, I had no option, because I was not going to make my already vulnerable son homeless. I found it particularly frustrating that it was just assumed he would come home with me, and that nothing further needed to be done by the ward. It felt like they were just trying to wash their hands of Jayden as soon as they could. I cannot understand why, at the very least, the hospital did not defer Jayden's discharge until his accommodation had been arranged.

106. No formal discharge plan was provided to me during this meeting. The discharge summary written by Dr B simply recorded that Jayden was to be discharged from section and was provided with a 7-day supply of PRN medication. I remember asking Jayden's clinical team: "*what happens now?"* They told me that Jayden's community team would take care of Jayden now. They told me that that team would be in touch. I was asking these questions as they were ushering Jayden and me out of the door. I understand now that Jayden was referred to the First Episode Psychosis ('FEP') Team for follow-up support in the community, though I was not advised of this at the time, and not told what this package of support would include.

107. I was told that Jayden would pack up his things, whilst the ward staff finished up the paperwork, and that I was to wait in my car for Jayden to come out.

108. I cannot describe how incredibly rushed this whole process felt. No one even sat down during this meeting. It was over so quickly. I did not have time to ask the questions I had. I left feeling so confused and unclear on the process. It all felt very last minute and rushed.

109. Jayden was subsequently discharged from Gosfield Ward later on 28 September 2020. I had no choice but to take him back home, even though I felt this was arrangement was very unsafe and bound to break down. Discharging Jayden was a huge, missed opportunity to properly assess and treat him. By discharging him, they allowed him to continue to deteriorate without appropriate safeguards or supervision.

110. On our drive home, following discharge, Jayden told me that his ward psychiatrist had said to him that if he took MDMA again he would end up like the severely ill people on the ward. It was almost used like a bargaining chip to him: do not take drugs, otherwise you will end up back here. It felt like the clinicians were putting the responsibility of addressing his addictions solely on Jayden. Staff treated Jayden as though his addictions were self-inflicted behaviour that he could control.

Community: 28 September - 19 October 2020

111. After Jayden was discharged from The Lakes on 28 September 2020, he had an initial assessment visit from the FEP Team on 1 October 2020. This was attended by a Community Psychiatric Nurse, C, and support worker, [I/S]. When they arrived, [I/S] C told me that it was very unusual for the referral to have been made to their service upon discharge, and not in advance, as part of the inpatient discharge planning process. She explained that the FEP Team usually had the first assessment with the patient whilst they were still on the ward, preparing for discharge, so that they could get to know each other and prepare a safe discharge plan. The relevant clinical record from this first assessment records Jayden's presenting problems as depression/anxiety and psychotic symptoms, as well as suicidal ideation. This was in notable contrast to his assessments at The Lakes, where the ward staff had repeatedly failed, or refused, to recognise his serious underlying mental illness.

112. Following this FEP assessment, the recorded plan was for Jayden to be taken on by the FEP Team for extended assessment, with the allocation to be reviewed in 3 months' time. An outpatients' appointment to complete this initial assessment was scheduled for Jayden.

113. On 6 October 2020, Student Nurse [I/S] and Nurse D from the FEP Team visited Jayden to complete an initial assessment. D was also Jayden's allocated care coordinator. I was upstairs when they arrived, but I came downstairs to introduce myself and ask for them to assist with completing Jayden's supported living referral form. D then asked if I could let them speak alone with Jayden, so I went back upstairs. I could hear Jayden answering their questions, saying he was fine, and that he had only said he would kill himself to shock and hurt me. I was concerned that Jayden was masking and saying the 'right' things to reassure the professionals that he did not need help, and that his issues were only around substance misuse and addiction. I became very upset and worried about Jayden presenting this version of himself that would once again leave him, and myself, without adequate support.

114. I tried to show the FEP staff the garage, where Jayden had been staying and which was in complete disarray, to get them to understand that he was putting on a front. I did become emotional during this meeting, out of frustration and fear that I would not be believed, similar to my experience with the staff at The Lakes. The FEP staff declined to see the garage and instead left, cutting short the assessment. They arranged to have another meeting with Jayden to complete the initial assessment and devise a care plan. The relevant case notes from this meeting

also indicate that I was to be offered a carer's assessment, though this never took place, and I was not aware of this even being offered at the time.

115. In the absence of sufficient support from The Lakes, I was given a supported living form from a Housing Solutions Officer at Chelmsford City Council, to be completed for Jayden. I tried to support Jayden to complete this form, and D also signed this before she left.

116. No further meeting or assessment took place with the FEP Team. As Jayden's initial assessment was never completed, no community treatment or support plan was ever devised for him. He therefore had very little input or help from the community mental health teams following his discharge. Our contact with D, Jayden's care coordinator, was very limited. I did not feel we were well or sufficiently supported by the community mental health services in this period, as I was assured we would be, and felt that I was just left on my own to try and keep Jayden safe.

117. I really struggled to support Jayden at home. Jayden decided that he wanted to go to see some friends in Bristol, in order to have some space and give me some respite. I was reluctant but his friends agreed that it might be good for him to get away and reassured me that they would look after him. I was so exhausted from caring for him and so I agreed.

118. Jayden went to Bristol on 9 October 2020. This was the last time I saw him in person, as he was getting into his friend's car.

119. In Bristol, Jayden spent time with his friends. I learnt later that he went to a rave with some friends, and took cannabis and MDMA. I was upset by this as I had thought his friends would try to keep him away from this, as they knew his alcohol and substance use was not good for his mental health. I understand, however, that Jayden often self-medicated using illicit substances when his mental health was deteriorating. He believed drugs helped him communicate with 'the universe'.

120. On 14 October 2020, I called the FEP Team to raise my concerns that Jayden was having another psychotic episode. He had been calling and messaging me in a way that I knew showed that he was deteriorating again. He then went quiet and stopped responding to me altogether. I contacted his friends to ask if he was OK. They said no, he had gone mute and vacant. This was something different that I had not seen in Jayden before. I could only get through to the FEP Team administrative secretary when I called, and she told me someone would call me back. Despite this, no-one from the team called me back until after Jayden was admitted to hospital, in a state of crisis, several days later.

121. On 18 October 2020, Jayden's friend [I/S] brought Jayden to A&E at the Bristol Royal Infirmary Hospital. He was worried that Jayden had had a psychotic relapse. I understand that Jayden was assessed by the triage team and thereafter referred for assessment by the Psychiatric Liaison Team. I note that the corresponding hospital records note that Jayden was assessed as presenting with "*evidence of immediate risk to self in context of untreated psychosis*". The

Psychiatric Liaison Team referred Jayden for an assessment under the MHA 1983. As there was some delay in arranging this, Jayden was offered a bed overnight, to get some rest, pending assessment the next day, which he accepted. His friend also stayed over in hospital with him. The accompanying hospital records note a plan for Jayden to be assessed for detention under s.5(2) of the MHA 1983 if he tried to leave at any point in the night.

122. In the middle of the night, I understand that Jayden tried to leave hospital as he thought his friend (who had stayed over with him) was plotting to kill him. Early in the morning, he walked out of hospital. No one stopped him from leaving. He eventually returned to hospital after being persuaded by the police to come back.

123. I called the hospital when Jayden returned, and they told me he was fine and did not require inpatient admission. I explained to them that Jayden was far from fine: he was having a psychotic episode and had just absconded. The hospital staff reported that he was making big arm movements, but they did not seem to understand that this was a reflection of his poor mental health. They stated they thought he was simply expressive or flamboyant and sought to imply, very insultingly, that his movements were somehow linked to his sexuality. I told the hospital staff that he needed to be properly assessed and detained. I expressly confirmed, when asked, that I was requesting an assessment under the MHA 1983 as his nearest relative. The staff member I spoke to said that I was entitled to request this as his nearest relative, but I would be wasting everyone's time. I understand that a referral was then made for a MHA assessment by the Psychiatric Liaison Team. The accompanying clinical entry notes this referral was due to Jayden's thought disorder, suicidal ideation and delusional beliefs about reading other peoples' minds.

124. I spoke to the AMHP, K, from Bristol City Council, on the phone and passed on detailed information about my concerns about Jayden and his circumstances. I explained, as is recorded in the clinical notes, that I felt Jayden required another period of inpatient admission, as I did not consider his psychosis had subsided by the point of his last discharge from The Lakes. I also raised with K that Jayden's suicidal ideations had, in the past, increased together with his psychotic symptoms, and reiterated my concerns over his ability to mask the extent of his illness. When she called me, K told me that the assessing team agreed that I should not have had to push for this assessment, and that it should have been obvious that Jayden required this. I note also, from the clinical records, that K tried to contact the EPUT FEP Team several times to obtain information about Jayden for the assessment, but received no response. The recorded MHA assessment describes Jayden as being under the bed covers, looking very scared and vulnerable. The AMHP observed that he was responding to unseen stimuli, and appeared thought disordered and confused, answering questions before he was asked them (as he knew what questions would be asked for this kind of assessment). As Jayden knew what questions he would be asked, I believe he was likely trying to pre-empt the questions to give the 'right' answer to avoid detention.

125. Following his assessment on 19 October 2020, it was decided that Jayden should be detained under s.2 of the MHA 1983. I spoke to the AMHP and asked her not to tell Jayden he had been detained until a bed was found for him back in Chelmsford. I explained that if he knew he was being detained, he would try to escape again. At around 7pm, after he was told he was going to be sectioned, Jayden escaped from the ward. I was told by the hospital staff that they had not been able to physically stop him due to Covid restrictions. This made no sense to me. The police were called and Jayden's friends were trying to find him. I think I spoke to Bristol Police and asked them if there was a train station nearby, and I told them he would likely try to go there. Jayden called me and was switching between asking me to come and get him, and telling me to leave him alone. His friends had to spend a long time convincing to get him to come back to his friend's house. Jayden eventually decided to go back to his friend's house as he wanted help and he was later brought back to hospital.

126. The corresponding records from the MHA assessments note that Jayden was exhibiting relapse symptoms, including delusions that he could channel other people and could hear their thoughts. The decision was made to detain Jayden under s.2 of the MHA 1983 and transfer him back to Chelmsford. In one of the two s.12 recommendations for admission, completed by Dr [I/S] [I/S], it was noted that "*In light of the deterioration in his mental state and lack of accommodation, his risk of vulnerability and further deterioration, cannot be safely managed in the community therefore section 2 is needed.*"

127. Jayden was transferred back to Chelmsford and subsequently admitted to Finchingfield Ward, at The Linden Centre, under s.2 of the MHA 1983 on the evening of 19 October 2020.

The Linden Centre: 19 - 23 October 2020

128. Jayden was only at The Linden Centre for four days before he absconded and tragically died.

129. When he arrived on the ward, I understand that Jayden was placed in isolation pending a negative Covid-19 test. I was advised to let Jayden settle in on admission, so I never ended up visiting him during the short time he was on the ward.

130. Jayden was and remained extremely unwell whilst he was detained. The inpatient records from this period refer to Jayden acting bizarrely, expressing paranoid ideation, and responding to hallucinations. He was fixated by the idea of sacrificing himself and on passing through to the next realm. Despite this, I note that various inpatient entries emphasise the fact that Jayden had not reported any active suicidal ideation since his admission, with no apparent recognition of the link between his psychotic symptoms and risk to self. It appears that this was relied on to downgrade his therapeutic observation levels from Level 2 (15 minutes) to Level 1 (hourly) on 21 October 2020. I was not involved in or consulted about this decision, nor invited to the first (and only) ward review concerning Jayden's care on 20 October 2020. At the time, I was led to

believe that Jayden was being checked on 3 times an hour up until the point he absconded. It was only at Jayden's inquest that I learnt this was not the case, and that by 23 October 2020 he was on the minimum level of observations.

131. Similar to Jayden's admission to The Lakes, I felt entirely shut out from his inpatient care at the Linden Centre. I remained in regular phone contact with Jayden at the beginning of his admission. It was clear to me how acutely unwell he was. I called the ward on 20 October 2020, to raise my concerns over his psychotic presentation, as Jayden had been sending me lots of messages about the Day of Reckoning and had been talking about needing to sacrifice himself. I had called him after receiving these messages and he answered the phone in a panic state, saying "*It's the day of reckoning, it's the day of reckoning, look at the colours on the walls*". I had never heard him that confused before, and it took a while for me to realise that he was genuinely petrified. He sounded very desperate for me to understand and reassure him that I could see also what he was seeing. This gave him a sense of relief, as everyone around him was telling him what he was seeing was not real.

132. I passed on a significant amount of collateral information about Jayden during my call to the ward on 20 October 2020, as recorded in the inpatient records, including his mental health history, his psychosis relapse indicators, and his ability to mask the extent of his illness. I do not feel my concerns were taken seriously, as no one called me back to discuss a safety plan for Jayden or to seek further information. I was really worried that, like before, Jayden would mask his symptoms and that staff would fail to appreciate the severity of his illness and risk level. I was particularly concerned that the staff night nurse, who I spoke to, appeared to be aware of Jayden's delusions but was laughing about this. I was given no information or reassurance about what the ward team was doing to help stabilise Jayden. I felt useless. I could not do anything to help him; all I could do was ask the ward staff to help him and hope they would listen. I was also very worried that the information about Jayden's high risk of absconding had not been handed over to staff on the ward. This had previously not been properly accounted for at The Lakes. I have since learnt that Jayden's records from the Bristol Royal Infirmary Hospital did not accompany him on his transfer and admission to the Linden Centre, so ward staff were not aware that he had escaped from hospital twice, in the immediate days preceding his inpatient admission, other than the general information I gave them about this.

133. On 22 October 2020, I was so concerned about Jayden's deteriorating behaviour that I rang the FEP team and spoke with CPN C. I explained to her that I feared, despite his admission, that Jayden's psychosis was getting worse and that the ward staff were not alive to or managing this. I also passed on that, earlier that day, Jayden had called me telling me he was going to escape by climbing onto the roof of the building. I was terrified he was going to try to abscond and put himself at serious risk. This information was not directly passed on to the ward team, before Jayden's absconsion. At the end of call, I was advised by C to take a break, to let Jayden settle down, and that Jayden was in a safe place.

134. Later, on 22 October 2020, I emailed a nurse on the ward, Nurse E, to inform her that Jayden had been sending highly distressing and inappropriate text and social media messages to friends and family, which were entirely out of character for him. One message stated: "*just to let you know I might be dead in the morning*". He was also messaging telling us to call the police and saying, "*help they're trying to beat and murder me*". It is so upsetting to me that his last message to me was something that I know he would regret saying, and he never got the opportunity to send me more messages as the Jayden I knew.

135. I attached screenshots of these messages to my email to E. I never received a response to my email. I asked for Jayden's phone to be removed from him, to protect his dignity. I had also expected my concerns would prompt an urgent assessment of Jayden's mental state and consideration of additional protective measures that may be needed, such as increasing his observation levels. Instead, as I only learnt after Jayden's death, the only step taken was to remove Jayden's phone from him. I also subsequently learnt, through the inquest, that Jayden had asked a member of staff during a dance movement therapy session that day to help him get out of the hospital. This was not escalated to his treating team after the session by the therapist.

136. In respect of 23 October 2020, I was not involved in the events leading to Jayden managing to abscond off the ward. I therefore summarise below my understanding of the sequence of events, as was established by the witness and documentary evidence received at the inquest.

137. Jayden's shift handover sheet for 23 October 2020 identified that he remained in his bedspace for the night shift, and he was described as "*calm & settled & polite*". In the day he accepted Haloperidol (an antipsychotic he had just been started on) and Lorazepam "*to good effect*". The handover shift for 24 October 2020 (after Jayden had passed), recorded in the night shift section: "*Low profile. Came out for physiological obs. Requested for his phone in the safe. Told to wait for regular staff replied 'ok'. Absconded soon after. Reported to have demised on the train track. Family aware. Datix and reports completed*".

138. Healthcare Assistant ('HCA') F arrived for her shift on Finchingfield Ward at around 19:03 on 23 October 2020. She was running slightly late for her shift, and had forgotten various items, including her pinpoint alarm and glasses, in her car. F attended the handover meeting in the nurses' office and told a member of staff that she had forgotten these items and would need to go back to her car to get them. At 19:30, Jayden was seen by staff tying his laces outside the nursing office. At 19:55, Jayden came to the nursing office to request his phone. He was told by a bank staff member that they did not have access to the safe and he would need to ask another staff member. Though this was not established at the inquest, I believe that Jayden was listening to the conversation inside the office and overheard F discussing needing to go back to her car.

139. At around 19:55, F proceeded to return to her car, going through three access-controlled doors using a fob key. F had not taken one of the extra pinpoint alarms located in the

nurses' office with her before she left to go through these doors and retrieve her own. This was despite her giving a bank staff member a pinpoint alarm from the office earlier that evening.

140. As was confirmed by the CCTV viewed at the inquest, F walked through all three locked doors without looking behind her to check if anyone was tailgating her, and without ensuring that the previous door was closed before she proceeded through the next one. I have not watched this CCTV footage as it would be too distressing, but it was shown at Jayden's inquest and my solicitors have viewed it. It reportedly shows that F did not check behind her at any point whilst going through these doors, despite not having her pinpoint alarm on her; which is for staff safety as much as for patient's safety. From the CCTV footage, it could be seen that Jayden would put his hand or foot on the door, to keep it from closing, and as F would pass through the next door he would quietly run behind her to catch the next door. As Jayden was going through the third, and final, access-controlled door, a staff member, [I/S] [I/S] can be very briefly seen on the CCTV looking through the viewing pane on the door. That staff member provided a witness statement that he did not see F or Jayden walking through the door, but I do not understand why he would have looked through the window pane if he did not see something.

141. After F had passed through the three locked doors, she entered the reception area to the Linden Centre. This area could be accessed by members of the public walking through motion-sensor sliding doors. It was only after F had stepped through the third door that she became aware of Jayden as he moved to pass by her. F attempted to hold Jayden's arms to try to prevent him from leaving, but he managed to shrug her off and ran past her, out of the building, through the automatic sensor doors and into the car park. F initially went to follow Jayden out, before returning to the reception area to press the ward buzzer in an attempt to alert other staff of the emergency situation. She could not alert staff immediately as she did not have a pinpoint alarm on her.

142. The CCTV footage then shows Jayden running through the car park and a car pulling out in front of him, with the headlights shining onto him. The driver of that car was a security guard, [I/S] [I/S], whose shift ended at 20:00. He had left his shift several minutes early (Jayden having absconded around 19:56), and was not at his post in reception when Jayden ran past F The CCTV shows that the security guard's car continued to drive past Jayden, not stopping to try to secure him and return him to the ward.

143. Senior Nurse E called the police (first calling 101, before later calling 999) just after 20:00. A preliminary search of the hospital grounds was then carried out by ward staff.

144. During Jayden's inquest, I learnt that there were significant communication issues between the ward staff and Essex Police regarding conveying the urgency and seriousness of Jayden's absconsion. When the call was originally made by E to the police, the police graded Jayden's absconsion as high risk. The investigation was then handed over to Sergeant [I/S]

who reviewed the information and downgraded Jayden's risk level to "Medium Risk – Non-priority". EPUT and Essex Police gave contradictory evidence at Jayden's inquest about the information that was shared. EPUT's position was that Jayden was high risk and that information was sufficiently conveyed to Essex Police for them to assess him as such, whereas the police maintained that the information they received led to an appropriate decision to designate Jayden as medium risk. I would however note that the police accepted they were made aware that Jayden had gone missing as a detained patient, who presented with psychotic symptoms and recent suicidal ideation, and that they had background knowledge of his previous missing episodes and thoughts about jumping in front of a train. I believe that this should have been enough, in itself, to classify Jayden as high risk, which could have led to a more extensive search with more specialist resources. Nothing was put on social media or in the public domain making appeals for Jayden or making the public aware he was missing. I believe that had this been done, together with the use of other police resources, there would have been a higher chance that Jayden would have been found.

145. A ward staff member called me at around 20:11, to tell me that Jayden had absconded. When they called, I immediately thought they were calling to tell me Jayden had died, as he was clearly suicidal and trying to escape. I provided details of various possible locations where Jayden could have gone. I told them that Jayden had previously spoken about wanting to go live in the woods, that he might have gone to [I/S] (which is where we found him during a previous missing episode) and also that he might go to a train crossing. He had previously told me that is where he would go to hang out with his friends. I believe he had also gone there one time when he had been missing before.

146. I learnt later that Jayden's friend, [I/S], who Jayden had worked with at the restaurant before he became unwell, ran into Jayden as he was walking through the [I/S] [I/S]. I believe it would have taken Jayden about 40-45 minutes to walk there from the Linden Centre. His friend told me that he asked Jayden if he was OK. He said that Jayden was looking lost, tired and vacant, but that he was not aggressive, just not the Jayden he recognised. He said that Jayden was swaying, looking distressed, and constantly looking fearfully behind him. Jayden told him "*I'm all good, I'm on a mission, I've got to go*". I feel that had the information about Jayden going missing been made public in an appeal on social media by the police, that friend have seen this and known to call me or emergency services about seeing Jayden, or could have talked Jayden in to staying with him.

147. I had been searching for Jayden from the moment I got the phone call. My friend lived very close to a train station, so I called her immediately to tell her what had happened and she went straight over to the station to speak to staff. She explained to them that Jayden might try to get on to the train tracks. Staff at the station asked to speak to me and I explained what had happened. They said something along the lines of "*oh not the Linden Centre again*". At Jayden's inquest, I learnt that a speed reduction on trains was initially put in place but was later removed,

as there had been no subsequent reports of Jayden entering the tracks or being at the station. Essex Police had not made British Transport Police ('BTP') aware that Jayden had gone missing, despite there being a BTP marker on his PNC. BTP said in their report that, had they been made aware, they would have taken steps to put a speed restriction in place, and to assist with the search.

148. I was searching everywhere for Jayden. I had been told by the Linden Centre to call 101 with any updates for the police. At one point that evening, I do not recall exactly when, I called 999 to speak to the police as I was advised by the 101 call handler to call 999. I thought Jayden might be near the B&M Store and wanted someone to search there. The man I spoke to said "*oh, not another one from the Linden Centre"*. He seemed quite annoyed that they were having to 'deal' with another absconsion from the Linden Centre.

149. Later on, I went home to charge my phone. I remember seeing a helicopter and thinking thank goodness, the police have listened and are using it to search for Jayden. I remember feeling less pressure then, feeling reassured to finally be seeing police presence in looking for him. I then drove to Broomfield and started searching the disused war-time bunkers, thinking Jayden might be scared and looking for shelter. I was worried he would be cold. I was searching everywhere for him; going through the woods, looking in ditches. I was terrified Jayden would die alone and be found by dog walkers one morning.

150. At around midnight, I think, I called the Linden Centre to ask them to get the police to use the helicopter to search a nearby field. I spoke to Nurse E She asked me if I had been home. Her tone was very calm, which was very different to earlier in the evening. I was getting really annoyed as she kept telling me to go home, but I needed to be out looking for Jayden. I asked her if she thought Jayden was scared, and could be hiding in the woods. Very solemnly, she told me Jayden had been very confused that day and I needed to go home. I remember finding that odd, as earlier she had told me Jayden had been improving.

151. As I was speaking to E, my friend, who was with me, received a call from Jayden's step-dad. He was insisting I needed to come home, but he would not say why. I knew then that what I feared had come true and that he would not tell me this over the phone. Distraught, I told E she had killed my son. I asked how this could have happened, how Jayden could have escaped from a secure unit. She told me that, technically, it was not a secure unit, and sounded very defensive.

152. As I was driving home I remember thinking, and hoping, that maybe my family had found Jayden and were not telling the Linden Centre so that he would not have to go back there.

153. My children and Jayden's step-sister were waiting for me in my kitchen. They were shaking their heads and saying "*I'm so sorry"* over and over. I then realised what had happened. I fell to my knees and kept saying "*no no no".*

154. Jayden had died after being struck by a train [I/S].

155. There was a BTP officer in my kitchen and I said to them, "*it was a train, wasn't it?"*. She told me it would have been quick, by way of confirmation. I did not find this particularly reassuring or compassionate. Later that evening, the BTP officers handed me a leaflet entitled "*What happens next when someone close to you dies on the railway*". I then realised that the helicopter I thought had been looking for Jayden was actually looking for his body. Essex Police had not deployed any helicopters or drones, due to his risk level only being graded as medium. Nor had the police told BTP that Jayden had gone missing, even though BTP had a vulnerability and risk marker for Jayden on their systems regarding risk of railways and trains.

156. I cannot put into words the acute sense of loss and devastation I felt, and continue to feel, at losing Jayden. His loss has ripped through our family, and left a huge void. I firmly believe that EPUT failed Jayden in their care, treatment and protection of him on multiple fronts, and that these failures directly contributed to his death, as I will set out further below.

Diagnosis

157. Jayden was given multiple, and confusing, diagnoses throughout his contact with mental health services. It seems that the primary diagnosis was drug induced psychosis and/or some form of personality disorder exacerbated by drug and alcohol addictions. I do not agree, and did not believe at the time, that these diagnoses were correct. From the time he started to show early warning signs of deteriorating mental health, from as early as March 2019, I was concerned that Jayden was showing signs of schizophrenia. This is because there is a family history of schizophrenia and I recognised some of the symptoms. Now, with retrospect and personal learning, I wonder if Jayden was actually developing schizotypal affective disorder.

158. Jayden had a background of harm-OCD and anxiety. As far as I am aware, this was never formally diagnosed, but something he and I always understood he suffered with. I also believe that Jayden had undiagnosed ADHD, as it is hereditary and I have this myself and other family members are neurodivergent. Jayden also presented with various behaviours consistent with ADHD.

159. I believe that Jayden's drug and alcohol problems initially developed as a way for him to self-medicate and seek to manage his psychological symptoms as he was not getting the mental health help he needed. His drug and alcohol use was also closely linked to his deteriorating mental health, as he believed that illicit substances would help him access the next realm. My understanding of ADHD is that individuals with ADHD have lower dopamine levels and are therefore more susceptible to addiction as a result of this. I do not believe that any clinical practitioner who assessed Jayden gave any or sufficient consideration to the fact that he could have ADHD, and how that might impact his behaviours, his response to medication, and/or his treatment plan.

160. I believe that Jayden's addiction issues were used against him by treating clinicians as a way to deny him treatment and to minimise his mental health issues. I was given the firm impression, throughout Jayden's involvement with mental health services, that it was easier for the professionals involved to blame Jayden's presentation on drugs and alcohol than to investigate the underlying psychological causes. Most of the mental health professionals that I had contact with appeared to share the view that if Jayden addressed his addictions, he would not suffer from ongoing mental ill-health. I strongly disagreed with this, and repeatedly sought to raise my concerns over Jayden's escalating psychotic symptoms in this period, in particular at The Lakes. I believe that the failure to properly diagnose Jayden was a key reason why he did not receive the standard of psychiatric care and treatment that his illness clearly required.

161. I believe that this attitude and approach began when Jayden was in the community and his mental health began to deteriorate. Many of Jayden's contacts with mental health services, both in the community and inpatient setting, culminated in professionals categorising his illnesses as 'drug induced'. It was as if the clinicians refused, despite the obvious pattern of psychosis, to see Jayden's acute presentation for what it was, using his addiction issues as a convenient justification for not treating him, either adequately or at all. Jayden's mental health was therefore allowed to rapidly deteriorate on account of a lack of early, appropriate diagnosis and intervention. There were several missed opportunities to identify Jayden's mental health and treatment needs, from early into his contact with EPUT, which could have obviated his severe and ultimately fatal deterioration.

162. At the time of his death, Jayden did not have a confirmed mental health diagnosis. As detailed below, various clinicians gave different and conflicting views as to his likely diagnoses over the period when he became acutely unwell. I did raise with several professionals my belief that Jayden had schizophrenia, and that drug-induced psychosis, for example, was not an appropriate diagnosis. However, I was not listened to. I felt a deep sense that no one could be bothered to take the time to properly investigate what might be causing Jayden's escalating behaviours and symptoms, particularly when he or I would tell professionals that he had also taken illicit substances. I had the distinct impression that it was easier for professionals to dismiss Jayden's problems as 'drug induced' and to blame him. This way he became someone else's problem, rather than accepting him as a patient they were required to treat and help. This also allowed them to blame Jayden and treat him as though it was his fault for having an addiction. Jayden and I were made to feel that it was for him to address his addictions first, stop wasting professionals' time, and that his problems were all self-inflicted. No one ever offered him support for his addictions; it was just seen as a way to wash their hands of Jayden.

History of diagnoses

163. Essex Police completed a 'Mental Health Street Triage Screening Form' on 4 September 2020 which records Jayden had "*Dual diagnosis;- Anxiety, OCD*". As far as I am aware, Jayden was

never formally diagnosed with this. This was repeated in the same form completed by Essex Police on 12 September 2020, following contact with the police.

164. When Jayden was admitted to Gosfield Ward, The Lakes on 15 September 2020, his inpatient records note "*there was no clear mental illness cause other than the substance abuse. He again admitted to using MDMA, cannabis, cocaine and alcohol*". In a ward review on 16 September 2020, his notes similarly record "*no clear mental illness. Sub clinical eccentricity. Very borderline schizotypal or borderline traits. Episodes of sub clinical depression?".* The unanimous view of the ward team at The Lakes was that Jayden was not suffering from a serious mental illness, and that his bizarre ideation was consistent with and caused by his substance misuse issues rather than any psychotic condition.

165. I remember going to The Lakes and feeling that staff were more concerned and interested with my mental health than Jayden's. I also expressly raised my concerns with their fixation on Jayden's addiction issues. I acknowledged then and do now that Jayden had a history of addiction, but I did not feel that this was the full story for Jayden. His poor mental health was far more complex than 'simply' addiction issues. I really wanted them to look into whether he could be developing schizophrenia.

166. I also remember feeling very upset by the stigmatisation Jayden faced, from the professionals at The Lakes ascribing his mental health issues to substance misuse issues and potential diagnoses of personality disorders. I was very worried that the clinical stigma and staff attitudes towards his problems would mean that his symptoms were not taken seriously, and that he would not receive the clinical intervention he required, which is exactly what happened.

167. On 26 September 2020, my mother wrote a letter to Jayden's treating team, which I provided to the professionals at The Lakes. In her letter, my mother wrote about how she had seen Jayden markedly decline over the past two years. She further wrote that she was aware of his substance abuse and how it could affect his behaviour. She raised her significant concerns for Jayden's risks. I do not believe that this letter was taken seriously. I was not aware, and am not aware now, that any steps were taken to reconsider Jayden's diagnosis whilst he was at The Lakes, having been made aware of our concerns.

168. At the point of Jayden's discharge from Gosfield Ward on 28 September 2020, the notes from his final psychiatric assessment recorded: "*Impr: Schizotypal/EU traits possibly disorder but needs further assessment in community setting".* Jayden received no further psychiatric assessment in the community setting. I was made to believe that Jayden was admitted to The Lakes to be formally assessed, with a view to formulating an appropriate diagnosis and treatment pathway, and that this was the purpose of s.2 of the Mental Health Act 1983. I do not understand why he was discharged without a confirmed diagnosis, when he still plainly needed assessment and treatment in a therapeutic environment.

169. Jayden's Discharge Summary, dated 29 September 2020, recorded his 'Final diagnoses' as: "*Personality disorder, Drug use, Alcohol Dependence F60.8, F10.2."* I was not made aware of this at the time. I would not have agreed with this diagnosis if I had known. I note that the failure to properly assess Jayden at The Lakes was directly criticised in the Trust's Patient Safety Incident Investigation Report ('PSII Report'), completed on 30 December 2020 following Jayden's death, which found that Jayden's admission represented a "*possible missed opportunity to consider all information that could have led to a robust assessment of a likely psychotic episode",* with Jayden's symptoms instead being wrongly accorded "*to be a part of the patient's personality construction".*

170. Following his discharge from The Lakes, I note that Jayden's GP subsequently recorded, in an entry on 28 September 2020, that Jayden misused drugs and had a diagnosis of unspecified personality disorder and alcohol dependency syndrome. Again, I was not aware of this at the time and do not agree with this diagnosis.

171. Similarly, when Jayden was assessed at the Bristol Royal Infirmary Hospital ('BRI') for s.2 detention, the s.12 approved doctor noted in the Form A4 that Jayden had been detained 4-5 weeks earlier with a diagnosis of drug induced psychosis.

172. Following Jayden's admission to the Linden Centre, I note that his 'Cluster Assessment' for 20 October 2020 recorded Jayden as having a "*severe to very severe problem"* in the category of "*drinking or drug taking"*. A related entry notes his 'Superclass' rating as: "*Psychosis"* with the 'Allocated Cluster' as "*First Episode Psychosis (with/without manic features)"*.

173. In a retrospective entry in Jayden's inpatient records on 24 October 2020, made by the on-call Consultant, Dr **[I/S]**, it is recorded that: "*JB had been admitted following history of psychotic symptoms and Personality problems. At this stage the diagnosis was unclear and this is possibly why he was admitted again on Section 2"* [sic].

174. Overall, I believe that there was a very distorted, confused, and unclear picture around Jayden's diagnoses throughout his care by EPUT. I did not agree with the various clinical assessments that characterised his addictions and substance abuse issues as a primary diagnosis in itself, rather than as a symptom of his psychiatric illness. I am particularly concerned that no consideration was given to whether he suffered from a serious psychotic illness. It was also very frustrating that mine and my mother's concerns and views as to Jayden's illness were not taken into consideration or treated with the necessary seriousness and respect. If our views had been properly accounted for, I believe this should have led to a full, informed assessment of Jayden's condition at The Lakes, at the latest, which identified that he was in fact suffering from a serious mental illness that required intensive treatment and monitoring.

Ward Environment

The Lakes

My views

175. Due to the Covid-19 pandemic, I was not physically allowed on to Gosfield Ward. I was only allowed to wait for Jayden in the waiting room. I recall having an impression of The Lakes as being quite chaotic, with little certainty or stability. One time when I was waiting at The Lakes to see Jayden, a psychiatrist arrived saying that he was there to work a shift, but staff did not seem to know him. They did not appear to be aware to expect his arrival, and were even struggling to understand why he was there. This gave me a strong sense that things were very chaotic on the ward, that the team did not know each other well, and that there was a lot of change and uncertainty in relation to staffing.

176. Another time, when I was waiting in the reception, some staff members came into the reception area speaking loudly amongst themselves. They seemed to be talking about another member of staff. I remember them saying "*if you don't like working with mental health patients, why are you working here"*, seemingly in relation to that staff member. I recall that that made me worried about who was working on the ward and how they were treating patients.

Jayden's views

177. When Jayden was first admitted to The Lakes he was put into isolation, due to the Covid-19 pandemic. Jayden told me that there simply was not anything to do on the ward all day. He told me patients were just hanging around, fights were breaking out, and that staff did not care and did not meaningfully interact with the patients I am not aware of any specific activities that Jayden was offered or undertook when he was at The Lakes. The most I was aware of was that he was allowed out into the garden space for cigarette breaks.

178. On one occasion whilst in The Lakes, Jayden sent me a text message saying that there was another patient who masturbated in front of him and spoke to Jayden in a sexually aggressive way. I have screenshots of these messages and am willing to share them with the Inquiry. I feel it is important Jayden's voice is heard, so I have copied below some of the various text messages he sent to me whilst at The Lakes:

- *He literally grabbed another young guy yesterday by the arm and did the same*
- *No mum I'm leaving this is sick.*
- *I've told them I feel unsafe and they did nothing*
- *I'm literally disgusted by this whole system*
- *Mum I need to get out of here asap this is the most painful thing ive gone through and I don't feel safe here with some of the patients like really unsafe*

- *They all know I'm fine they chat with me normally but they are just keeping me in here! I'm literally gonna sue this place if I can*
- *I am not staying here it's like being in a cage*
- *I feel like a circus animal with a rapist threating me*
- *Because they don't give a shit*
- *They just watched a fight happen 3 times the other day*

  [sic]

179. My overall impression, from what Jayden reported to me, was that The Lakes was a tense and unsafe ward environment. By way of example, in an inpatient entry dated 23 September 2020, it is recorded that Jayden approached staff in the evening stating "*he feels unsafe in this present loud environment on the ward, presenting as anxious".*

180. When Jayden was discharged from The Lakes he seemed to have a heightened sense of empathy for the other patients. He worried about them still being in hospital, seemingly due to it being such an unsafe environment. When I was driving home with Jayden following his discharge from The Lakes, Jayden told me "*we have to do something about that place"*. He described in some detail the way staff talked to patients: rudely, cruelly, and with no empathy. He also reported that staff could be intimidating, aggressive, and threatening. Jayden seemed genuinely fearful for the patients still on the ward and was very clear that something needed to be done to help them get out of that environment.

181. I do not know if there is or was an airlock system on the doors in The Lakes. I want to understand from the Inquiry if the hospital does have this system, and if one was in place at the time of Jayden's admission, as I feel it is very important all doors on secure units should have airlock systems.

<u>The Linden Centre</u>

Security

182. I understand from the PSII Report that, on the day he absconded from the Linden Centre, Jayden was asking for his phone at the nurse's desk. As detailed above, I had asked for Jayden's phone to be removed from him because of the distressing messages he was sending and my fear that, when he was well again, he would be very upset at the messages he had sent. From the evidence we heard at his inquest, I believe that around the time that Jayden approached the nurse's station to request his phone, the HCA he tailgated, F told the staff in the nurse's station that she had left her pinpoint alarm and glasses in the car, so she needed to go out to get them. I believe that Jayden very likely heard her saying this and knew he could take this opportunity to tailgate her out of the ward given the poor physical security on the ward. I am concerned about the location of the nurse's station, which allows patients to listen in on conversations that may be confidential.

183. To this day I remain distraught and in disbelief as to the lack of vigilance and/or awareness shown by HCA F, when working with such vulnerable, detained patients to walk through three sets of locked doors without checking her surroundings. HCA F walked through three fob locked doors without looking behind her, pulling the door shut behind her, or listening out to hear the door close. She had three opportunities to ensure Jayden did not tailgate her out of the ward, and missed all three. I was also concerned to hear at the inquest, as shown on the CCTV footage, that a staff member may have seen Jayden tailgating through the outside glass panel of the door, and did nothing about this at the time. I would like to know if he did in fact see Jayden and, if so, why he failed to do anything.

184. At Jayden's inquest I also heard how, when Jayden ran away, because HCA F did not have her pinpoint alarm on her, and had not taken one from the spares drawer before she left the ward, she could not easily call for help. She had to repeatedly ring the buzzer in the reception area to try to get someone's attention. She had no other way to communicate with staff.

185. At the time Jayden absconded, the doors leading to the reception area from the car park were automatic. Once Jayden had followed HCA F through the three locked doors, he was able to run past her and out of the automatic doors. As the PSII Report later found, these main doors were not at the time, but should have been, security controlled, instead being operated by a motion sensor. I understand that, further to a recommendation from the PSII Report, an intercom system was installed the week following Jayden's death, which now requires members of the public to be buzzed in. Sadly, we know that Jayden was not the first person to abscond from the Linden Centre, so I do not understand why it took his death for these security arrangements to change.

186. I have similar concerns about the airlock doors, that were only installed at the Linden Centre following Jayden's passing. At the time of Jayden's death, unlike many other of the Trust's inpatient wards, Finchingfield Ward did not have an 'airlock' time delay system in place which provides that one door cannot open until the last one closes and would substantially delay any attempt to abscond in circumstances similar to Jayden's. EPUT knew, or ought to have known, that the absence of such a system, in the context of a ward with vulnerable detained patients, was neither safe nor secure. EPUT were well aware of the high risk of absconding from Finchingfield Ward already, and across the estate, prior to Jayden's death. I cannot understand why it was not until Jayden's death that they installed an airlock system and took steps to strengthen such fundamental security measures. EPUT had had enough opportunities before Jayden's death to know the doors were inadequate. Why did they have to wait for my son to die, to change them?

187. On 23 November 2020, Mr Paul Scott, the Chief Executive of EPUT, wrote a letter to Kemi Badenoch MP and Vicky Ford MP in relation to concerns they had raised on my behalf regarding Jayden's absconsion. In his letter, Mr Scott explained that they had invested £2.4m in "*safety improvements*" at the Linden Centre. Mr Scott's letter went on to state that Jayden's passing was "*the first death*

following a patient absconding from the unit, and, since the death of Richard Wade in May 2015, we have had no further inpatient deaths at the Linden Centre so the increased safety measures appear to have minimised the risk to patients." I found this very distressing and upsetting to read. Any death is one death too many. This letter also ignored the high number of absconsions, and many "near misses", that had happened before Jayden's admission, and subsequent passing, at the Linden Centre. I note for instance that the CQC inspection of Finchingfield Ward carried out in late 2020, very shortly after Jayden's death, observed that poor staff compliance with patient safety measures had contributed to the incidence of patient absconding. Mr Scott's letter reads as though those absconsions were not, in themselves, concerning. I felt his general assertions about safety improvements were inconsiderate and insensitive.

188. When Jayden was admitted to the Linden Centre, I went home and researched it online. I saw that it had poor reviews and recent CQC reports. I remember thinking that that they would be actively trying to get better and improve their inpatient environments, given the concerns raised that I read about at the time. I thought it meant that ward staff and management would know it was being closely scrutinised, and so they needed to provide a good and safe service. Tragically, this was not the case.

189. The PSII Report identified that the ward systems and processes failed to prevent Jayden from absconding on 23 October 2020, when they should have done. It accordingly found that various issues on Finchingfield Ward directly contributed to this systemic weakness, including the inadequate physical security features (including the absence of intercom and airlock systems) and the design of the ward environment itself. It was found that, unlike other newer wards, where the nursing station is specifically positioned to have direct sight of the entrance, the nursing station on Finchingfield Ward had inadequate sight lines of the ward entrance. A clear line of sight from the nursing office could, the report considered, have alerted staff to Jayden's attempt to abscond. Furthermore, the design around the ward exit doors was such as to provide access to lots of other communal patient areas (such as the garden and kitchen), which the investigation found meant that patients regularly congregated around the entrance areas and increased the risk of patient absconsions from these areas.

190. The PSII Report further identified that there had been no attempt to obtain photographic ID from Jayden upon his admission, and that there was no recording of his clothing description despite this being required by Trust policy. This had obvious implications when the Trust reported Jayden as missing to the police as it impacted the extent and accuracy of the information they were able to pass on about him. The PSII Report recommended that the ward should strengthen its processes in recording photo identification and description of clothing for those patients at risk of absconding.

Environment

191. As detailed above, Jayden was brought to the Linden Centre to be assessed by Dr **G for**

inpatient admission before he was admitted to The Lakes. This was the only time I went to the Linden Centre. When we were waiting at the Linden Centre to meet with Dr **G, I remember** there was a very loud alarm that went off. I believe this was to signal to staff that there was an emergency incident to attend. I recall that staff reacting to the alarm were walking, not running. It was a loud, distressing sound. I remember thinking it seemed more like a prison; like something out of a movie about a high security prison ward. I also worry now how awful hearing that alarm must be for patients in the ward.

192. I was told to let Jayden settle in when he got to the Linden Centre, so I never went onto the ward during the few days he was there. When I spoke to Jayden on the phone in the Linden Centre, he was initially in Covid isolation. I understand that the ward staff had lost his tests, so he had to stay in isolation longer than normal. On one occasion, while I was on the phone with him, I could hear him saying "*help, get off me"* and I could hear a man shouting at him to get back into his room. I believe this was a staff member. Jayden was making sounds as if he was in pain and imploring the man to get off him. The man sounded aggressive, though I do not know what was happening. Jayden was very sensitive to touch when he was suffering from psychosis, so I do not know if staff were touching him to move him on and if this was painful or alarming to him.

193. I also believe that staff mocked and demeaned Jayden. One time when I was speaking to Jayden on the phone while he was detained, he said "*they told me that if I have special powers why don't I use them to open the doors"*. Jayden told me "*but I told them, mum, that's not how my powers work"*. He sounded very sad and disheartened talking about this. It seemed clear to me that the staff were mocking him about his delusional beliefs of having powers and being able to communicate with other realms. Given this was a clear symptom of his psychotic illness and his confused state, this mocking seemed extremely cruel to me.

194. The overall impression I have of Jayden's time on the ward is that it was a very lonely, scary place for him. Similar to The Lakes, the staff appeared remote, uncaring, and passive. I worry that he was taunted by staff while on the ward, who misinterpreted and even mocked his acute symptoms. It felt to me, from what Jayden told me and how he presented, to be a harsh and even hostile clinical environment – the very opposite of what a therapeutic inpatient ward should be. Moreover, after Jayden was administered antipsychotics in the Linden Centre, he became very disinhibited. I do not believe this was managed adequately by staff, and that he was exposed to other patients in a very vulnerable state.

195. I do not believe that Jayden's privacy or dignity were respected during either of his inpatient admissions. He was mocked, ignored, and taunted by staff. I feel he was left entirely on his own in an uncaring and inappropriate clinical environment.

Staffing Arrangements, Training and Support

Communication

196. When Jayden went to The Lakes, I was never told who his assigned keyworker or care coordinator was, and who I could speak to specifically about his treatment. If I wanted to speak to anyone about Jayden, I had to call the generic ward number. Halfway through Jayden's admission, the phone number at Gosfield Ward just stopped working. No one had informed me that the ward number would be changing. I had to call other wards to get the new phone number. I also had to call the Responsible Clinician Dr **B's secretary** direct number to get through to anyone. When I called she was more focused on how I got her number than helping me get in touch with the ward. Having no single point of contact meant that I had to rely on telling whichever staff member I spoke to at the time to act on the repeated concerns I was raising about Jayden, and to relay this information to the team and record it correctly in Jayden's notes. I was not even aware about the role of a keyworker or care worker; if I had known about that I would have asked who was allocated to Jayden or asked for someone to be allocated to him. There was absolutely no staff continuity in the supervision or care of Jayden.

197. There was one staff member at The Lakes, **[I/S]** who Jayden got on well with and who was really kind to him. However, this is the only staff member I remember positively from The Lakes. It felt very unusual to have someone showing kindness and compassion to Jayden, which, looking back, is particularly striking given this was a mental health inpatient setting, where such characteristics should have been expected and familiar.

198. When I first went to visit Jayden at The Lakes, I believed I was going to see him on the ward. Given the difficulties we had had in getting him admitted, and with him repeatedly running away from home, I assumed they would not want to grant him leave straight away for fear of his absconding. However, when I arrived the at The Lakes, Jayden came out with a staff member who said "*here you go then"* and essentially handed Jayden over to me. I became really worried then as it dawned on me that Jayden was being granted leave. I spoke to the staff member and asked if he was aware that Jayden had had a history of running away, and he said that he did not know this. I asked him to take a note and ensure it was clearly recorded on Jayden's file. I reiterated that Jayden could not be let out on his own, or he would run away. I had to have this conversation in front of Jayden which was very upsetting for him. It was very hard having to speak about my concerns for Jayden in front of him; it created a lot of tension between us. I was very shocked and concerned that the staff who were responsible for his care and leave seemed to know so little about Jayden but were overseeing his leave.

199. In the lead up to Jayden's subsequent admission to the Linden Centre, on 18 October 2020, I was desperately trying to contact staff in the FEP Team, after Jayden was admitted to BRI, to tell them he was unwell and had been admitted to hospital. I wanted his community treating team to be aware that Jayden was seriously unwell and needed urgent admission. I had been told to contact his care coordinator, D, if I ever had concerns about him. I could not get hold of anyone from the FEP Team over the weekend, nor the following week, once Jayden had been admitted to the Linden Centre. It took several days for anyone to get back to me, by which time Jayden had already been admitted. I understand that staff from the BRI were also trying to get in touch with FEP, for collateral information about Jayden's condition, but could not get through to anyone. This was very frustrating and upsetting because I did not know the process for hospitalisation and was really concerned for Jayden. I thought his care coordinator should have been keeping me informed and updated, rather than the other way round.

200. When Jayden was admitted to the Linden Centre on 19 October 2020, I was not given any information about who his treating psychiatrist was or his treatment plan. I specifically asked for Jayden not to be put on antipsychotic medication, because I was worried about how he could react to it given his sensitivity to this medication in the past. I was not listened to nor informed when he was in fact commenced on antipsychotic medication. I felt like I had to fight to be heard by the staff at the Linden Centre, who never my views on his treatment or information about his clinical history.

201. Similar to The Lakes, communication at the Linden Centre with ward staff was very limited and entirely led by me. If I did not call, I would not hear from anyone on the ward. I was calling often in those few days to raise my concerns about Jayden and how unwell he was becoming. He was messaging me, and his friends, whilst on the ward, expressing bizarre and suicidal ideation. I was becoming increasingly worried about his presentation. He told me that he wanted to get out, and to sacrifice himself. I raised this with ward staff when I called, as well as with Nurse C from the FEP Team, and trusted this would be documented and escalated to Jayden's treating team. At Jayden's inquest, we heard evidence from staff on shift the night he absconded who said they were not aware that Jayden had talked about escaping and sacrificing himself.

202. On 23 October 2020, after I had been informed of Jayden having absconded, I called the ward back to ask questions such as whether he had his wallet on him. The female staff member I spoke to kept asking if I was talking about 'Jason' and didn't seem to know who Jayden was or that he was missing from the ward. That was deeply frustrating and worrying to me, as my vulnerable son was missing but ward staff did not even seem to be aware of this, let alone be capable of giving me the basic necessary information to help find him. The situation seemed very chaotic when I was trying to speak to the ward that night, and indeed throughout all my communications with them.

203. The PSII Report also found numerous weaknesses in respect of internal ward communication on Gosfield Ward. The report concluded that issues in written and verbal staff communication, congruence of role and responsibilities, task factors, communication flow, staffing levels and skill mix, and incomplete information "*conspired to weaken the effectiveness of communication and limit team function in having a shared mental picture of what needed to be done, when and by whom*".

204. A question I would like the Inquiry to look into is whether there is a way for the record keeping system to show who has historically amended the records, and when. I am very concerned that certain entries in Jayden's records were retrospectively added and would like to understand whether this would always be clear from the system.

Observations

205. As I have already explained above, when Jayden was at the Linden Centre, I had been led to believe that he was being observed on Level 2 observations throughout. However, it only came to light at the inquest, that when he came out of COVID-19 isolation, on 21 October 2020, he was immediately and automatically downgraded to general observations. This meant that, instead of being observed four times an hour, at random intervals, he was only being observed once an hour. Jayden had only been on the ward for two days by this point during which time, as the records note, he continued to present as very delusional and responding to hallucinations.

206. As was established at the inquest, and confirmed in the PSII Report, this reduction was not made in line with Trust policy, and did not follow the observation care plan made for Jayden written by his named nurse. This care plan specified that Jayden's observation levels should only be reduced following agreement by the multi-disciplinary ward team, factoring in his risk of absconsion and impulsivity. I was not made aware of this reduction in his observations and believed, throughout Jayden's admission at the Linden Centre, that he was being observed at least three times an hour. Had I known this, I would have raised my concerns straightaway that Jayden was acutely unwell and required a far higher level of supervision, especially given he was expressing suicidal ideation, speaking about wanting to escape, and had just been started on very strong antipsychotic medication.

207. The PSII Report identified that, had Jayden remained on Level 2 observations, this would have allowed for a more "*heightened level of engagement",* which may have given staff the opportunity to "*have detected behaviours such as an unusual interest in exit routes, which may have indicated impending attempts to abscond".* The investigation found that staff were not fully aligned with the expectations in the Trust policy on observations, and that there was an over reliance on nursing staff to manage observation levels, with doctors

demonstrating a "*passive approach*". It also found that there were misunderstandings amongst staff as to when observation levels could be reduced, that clinical risk training had been attended at the right level, and the record-keeping concerning the observation changes were sub-optimal. The decision to downgrade Jayden's observation levels, underpinned by these factors, was identified as a key care and service delivery problem in respect of the circumstances informing Jayden's death.

208. It is devastating to know that Jayden should have been on a higher level of observations, and that this could have prevented him from escaping that night. It is even more devastating to have only learnt that he was not on the higher level of observations, as I had been told he was, after his death. Had I known he was only on general observations, I would have pushed for this to be urgently reconsidered as I knew, as well as staff, that he was at such high risk of escaping. Instead, I was repeatedly reassured that he was safe and being observed regularly.

Staffing levels

209. It was very difficult to get in touch with ward staff at the Linden Centre during Jayden's admission. The inquest confirmed there was a high proportion of temporary staff on the ward, who did not seem to know who Jayden was, let alone know him well enough to be aware of changes or risk indicators in his presentation.

210. From the information I learnt at the inquest, it also became clear that staffing absences caused significant issues with information-sharing and handover at the Linden Centre. For example, the nurse allocated to create Jayden's care plan failed to complete it fully and did not hand this work over to anyone else before going on leave. Jayden's final care plan, which is a critical inpatient document setting out his risks and clinical needs, was therefore never completed.

211. The PSII Report further identified that two junior doctors had limitations on their practice as health reasons required that they did not come into face to face contact with patients that had unknown COVID-19 results. This significantly limited their contact with Jayden and ability to monitor his presentation first hand, and delayed the completion of a repeat ECG that was required before Jayden's antipsychotic medication dosage could be increased. As it was, due to the late stage of this repeat ECG, Jayden's antipsychotic medication was never increased as planned. I do not understand why there were insufficient junior doctors available to undertake these vital tasks. Given the ward were well-aware of the restrictions on some of their staff, they should have arranged to have additional medical cover to ensure that Jayden received an appropriate and timely level of care.

Staff attitudes

212. When Jayden was at The Lakes, I remember being very concerned about the professionals' negative views towards Jayden's drug taking and addictions. They seemed to assume he was taking drugs recreationally, as part of his general lifestyle, as opposed to it being a direct effect of his psychotic illness. Jayden's drug-taking was closely connected to his delusional ideation about spirituality and other realms; he believed that taking drugs would help him transcend to the next realm. It was deeply frustrating to me that the staff at The Lakes showed no professional curiosity as to why Jayden maintained his beliefs about other realms on the ward, even when he was not under the influence of drugs. No one was asking the question why he believed in other realms when he was not on drugs.

213. I have significant concerns about the level of complacency and desensitisation shown by the ward staff, particularly at the Linden Centre. At the inquest, staff presented as blasé or unphased in their evidence about Jayden's unwell presentation and the circumstances of his absconsion. Their evidence left me with the distinct impression that staff were simply not sufficiently considerate of the seriousness of the risks on the ward on which they were working. That the HCA was not aware that she was being tailgated by Jayden, and that another staff member may have seen Jayden doing this through the door but did not intervene, concerns me greatly. It gives the distinct impression that staff were complacent and not alive to the seriousness of the risks on the ward on which they were working.

214. I was also very concerned to learn in Jayden's inquest that the security officer at the Linden Centre saw Jayden run off, but did not attempt to stop him, because he had finished his shift. We heard evidence that Jayden absconded at approximately 7:56pm. As I describe above, the security officer's shift finished at 8pm, but he left his shift up to ten minutes earlier. The officer gave evidence that he saw Jayden run away, as his shift had ended and he thought staff would deal with this, he didn't do anything. He said that he did not know the patient and said he would not have been able to assist in the search for Jayden in any event. The lack of empathy or concern to not have even stopped and tried to intervene was very upsetting to hear. I feel so upset and horrified by this, and about the number of people who failed to help Jayden when they had such obvious and numerous opportunities to do so.

215. All of my interactions with staff on both wards were over the phone or email. As I have already made clear above, I would call staff, repeatedly, raising my concerns over Jayden's worsening psychotic symptoms and suicidal ideation. They did not pro-actively call me to obtain or pass on information about Jayden. On one occasion at the Linden Centre, when I called and spoke to nurse E, I recall that she laughed when I expressed my concerns over Jayden's deteriorating symptoms. I explained that Jayden was telling me that it was the Day of Reckoning: in response, she simply laughed, saying that he

would have a surprise when he woke up the next day. Nurse E also casually told me, laughingly, that Jayden was talking to people who were not there, without any apparent concern that this was consistent with a hallucination and a characteristic sign of psychosis. This gave me the impression the ward environment was not compassionate or caring.

216. Another example of staff complacency was made apparent to me on reading in the PSII Report that staff on Finchingfield Ward were copying and pasting sections of the Situation, Background, Assessment, Recommendation, Decision ('SBARD') clinical notes into new sections. This lack of attention to detail meant that Jayden's notes were not accurate or updated with key risk-relevant information about his presentation.

217. The extent of staff's desensitisation was made very apparent during Jayden's inquest. The only EPUT professional who appeared to show any remorse for her actions was C [I/S], from the FEP Team, in respect of her failure to record or pass on my concerns raised with her, whilst Jayden was at the Linden Centre, that he had said he wanted to escape, specifically that he wanted to jump from the roof. In the inquest she apologised for this oversight, explaining that she failed to action this due to a high workload. She at least showed compassion and humanity, which I greatly appreciated, and we comforted each other at the inquest. This was starkly contrasted with the defensive attitudes shown by the senior clinicians, and the deflection shown by more junior staff members, who repeatedly stated they could not recall in answer to questions.

218. While Jayden was detained, I truly believed and hoped that staff were taking my concerns seriously. But clearly, they were not. Information I provided about Jayden often did not get recorded, and even when it did get recorded, it seemed to make little difference to the clinical decisions that were made for Jayden's care including granting him leave, discharging him, and medicating him. I felt fobbed off and isolated from his treatment. At The Lakes especially, staff appeared to accept at face value Jayden's assurances that he was not mentally unwell and his attribution of his problems to his home life, despite my repeated attempts to warn them that he was minimising the severity of his symptoms. I was treated as the overbearing, neurotic mother who needed platitudes and reassurance. I thought Jayden was in a place of safety, but he was not.

219. The PSII Report also identified that medical leadership took a passive, rather than proactive, approach to Jayden's needs. This aligned with my view on Jayden's treatment, that he was simply living on the ward being medicated and was not receiving proactive treatment, tailored to his psychological needs, to help him get better.

220. My experience of the inquest left me feeling that a lot of staff members were simply operating on autopilot and had become dangerously detached and complacent. This

contributed to the wholly inadequate care that Jayden received, which ultimately cost him his life.

Staff competence

221. I was, and remain, highly concerned about the poor level of competence and knowledge demonstrated by ward staff in dealing with very vulnerable patients. I have already detailed above the various ways in which staff failed to meet, in my view, the standard of care expected of them as clinical professionals. There were repeated instances of poor communication, both between staff and with us as the family, non-compliance with or poor understanding of Trust procedures, and a lack of any professional curiosity or pro-active care-planning in respect of Jayden's inpatient care and risk management.

222. The PSII Report criticised, for instance, the various staff misunderstandings and omissions in respect of Jayden's inpatient documentation at the Linden Centre. Not only did this result in Jayden's 72-hour full care plan not being formulated, as above, but in inadequate information being recorded as to his risk history in his 'SBARD' nursing notes. The staff member responsible for updating Jayden's notes on admission on 19 October 2020 was under the misimpression that they only needed to record Jayden's immediate or current risks, so omitted to record his significant risks of absconding and impulsivity. This was notwithstanding that the admitting team were well-aware of these risks, as they were detailed in the AMHP documentation handed over. This led to a disjointed and incomplete understanding, across the ward team, as to the nature of Jayden's risk profile. The PSII Report found that this meant, in practice, that at least twice daily, the staff directly caring for Jayden missed the opportunity to be informed and reminded of these important risks.

223. At Jayden's inquest, evidence was heard that staff called 101 when Jayden absconded, and not 999, following guidance on a sign in the nurse's office. They said that they did this because that is what they were told to do. I was shocked and deeply distressed by this. Jayden was extremely and acutely unwell, something every witness from the Linden Centre agreed with at the inquest. That staff did not know or think of the need to call 999 instead of 101 in an emergency was very disturbing to me. This was especially so because the staff member who made the call had worked in the mental health setting for over 15 years and was a permanent member of staff.

Treatment

Therapeutic treatment

The Lakes

224. I was not aware of any form of therapeutic treatment or activities being provided to Jayden at The Lakes. He was given a small, Sudoku book when he was first admitted, to help him with boredom during Covid isolation. I do not think it was a very helpful activity for someone who was suffering with psychosis. Moreover, a manifestation of Jayden's illness was that he took 'numerology' very seriously, and thought that numbers gave him signs and hints from the universe. If anything, this type of activity, when left alone in isolation, would have exacerbated his psychological symptoms. I note the clinical records also reference Jayden being given a 'self-isolation' pack and a cup of tea from an occupational therapist whilst isolating. There is nothing to indicate he was seen again by this occupational therapist for any more meaningful form of intervention.

225. On 24 September 2020, the clinical records note that Jayden was invited to the 'Get up and move' session, which was table tennis, by a HCP Therapist, [I/S], but he declined. For the rest of the day his records note he was '*relaxing*' in his bed space, and that he took escorted leave with me. I am confused by the term 'relaxing'. Jayden was not 'relaxed' while he was on the ward: he was actively and persistently psychotic. This type of terminology makes it sound like he was at a spa or on holiday. I believe staff would simply write 'relaxing' when in fact, Jayden was doing nothing, in order to avoid actually engaging with him and assessing his mental state.

226. I note that, in the case notes for 21 September 2020, the plan is recorded as: "*Refer to Psychology to explore Jayden's concerns/risks. Etc. Jayden requested psychological support*". This follows from an earlier entry in the records, concerning the ward review on 16 September 2020, which also refers to Jayden being referred to psychology. Notwithstanding this, Jayden did not receive any form of psychological treatment or intervention whilst at The Lakes or indeed in the community following his discharge. It is not clear to me what if any treatment he received, beyond being sedated.

227. When I raised the absence of any therapeutic treatment at Jayden's discharge meeting, including my concerns that he required therapy before being discharged, I was told that he had had been given a 10-minute conversation with his psychiatrist earlier that day. I felt gaslit by this; it was made out to me that this small chat was a sufficient replacement for the therapeutic treatment we were promised, which it was obviously not.

The Linden Centre

228. Jayden was similarly not offered any psychological treatment whilst at the Linden Centre, despite the clinical records noting he had previously requested this.

229. The inpatient case notes appear to indicate that Jayden was too unwell to participate in '**therapeutic groups**', **though it is unclear what these groups entailed and the extent to which** they were explored with Jayden.

230. **Jayden's** clinical records state that he was on the phone all day to his mum, but this was not the case. I think he likely thought he was speaking to me in the room, having a hallucination, which is consistent with the various references in the records to him responding to unseen stimuli on the ward and presenting with bizarre, delusional behaviour. In any event, it seemed like this was being treated as a therapeutic activity in itself, for Jayden to be on the phone, and another example of staff avoiding having any meaningful form of engagement with him.

231. Jayden did have a movement therapy session **[I/S]** on 22 October 2020, which I think was good for him. He liked dancing, and the notes showed that he was very gentle on his feet. The therapist recorded that he was caring and kind to her, putting a blanket over her when they did a grounding technique as he was worried she would get cold. I found this particular detail very moving to read – it summed Jayden up as a person, endlessly caring, even when he was so unwell. I note however that, also during this session, Jayden asked the psychotherapist for help in getting out of hospital. As was established in the PSII Report, this comment was not properly risk assessed, recorded, or escalated to senior staff members, despite the psychotherapist observing that Jayden appeared thought disordered, psychotic, and was struggling to form coherent sentences.

Medication

The Lakes

232. When Jayden was at The Lakes, his psychiatrists spoke to him about trialling him on new medication. They did not speak to me about medication at all. I believe they discussed antipsychotics with Jayden, though I have not been able to find evidence of this in the records. I did not want Jayden to be prescribed strong medication; **[I/S]** **[I/S]** **[I/S]**. I was concerned that Jayden had undiagnosed ADHD and may suffer from adverse side-effects to this type of medication. Jayden also said he did not want to be prescribed medication. I raised these concerns with staff, but they did not discuss medication or any treatment plan with me.

233. It is recorded in Jayden's medical notes that, on 14 September 2020, Dr [I/S] completed a medication administration chart and confirmed as required (PRN) medicines of promethazine and lorazepam to be administered of 25-50mg, Promethazine, with a max. dose of 100mg, and 1-2mg of Lorazepam, with a max. dose of 4mg.

234. On 15 September 2020, the prescription chart was updated as follows:

Drug	Route	Indication	Dose	Max. Dose
Promethazine	PO	Agitation	25-50mg	100mg
Lorazepam (see IM)	PO	Agitation	1-2mg	4mg
Zopiclone	PO	Insomnia	3.75-7.5mg	7.5mg
Lorazepam (see oral)	IM	Agitation	1mg	2mg IM
Nicorette inhalator	INH	NRT	15mg cartridge	6 cartridge

235. Jayden's medical charts show that Jayden was given PRN medication every day in The Lakes. I am concerned that the only plan for Jayden was to sedate him with this combination of PRN medication whilst he was detained. It is not clear to me that there was any other plan for treatment, monitoring, or helping him to improve other than to medicate him to the point of sedation. I believe that this combination of medication also prevented staff from properly assessing and identifying the extent of Jayden's psychotic symptoms whilst on the ward, as it operated to further mask his true presentation.

Bristol Royal Infirmary

236. During his short admission to the BRI, on 18 October 2020, the records indicate that Jayden was administered 5mg of Olanzapine. I do not know why this was prescribed and administered before his transfer; my understanding is that this is a very strong antipsychotic medication that requires close supervision and monitoring. It is not a PRN or one-off drug but needs to be administered as a carefully planned course of treatment. As far as I am aware, Jayden had never been administered any form of antipsychotic medication before this point, either in respect of his community or inpatient mental health care. It baffles me that he was only given one dose, with no apparent treatment plan for ongoing prescription, and that this was not a medication that he had been previously prescribed.

The Linden Centre

237. I had serious concerns about the antipsychotic medication, Olanzapine, that Jayden was put on when he was admitted to the Linden Centre. Jayden had been clear previously about his wishes not to have prescribed medications such as anti-depressants or antipsychotics. I

worry that because Jayden had been prescribed Olanzapine at the BRI, staff felt this was appropriate medication for him to continue, without proper review, consultation or consideration. Jayden was acutely unwell when he was in the Linden Centre; I had never seen him so unwell and disconnected from reality. He clearly lacked capacity to make decisions about his medication. I felt that his treating psychiatrists therefore used this as an opportunity to override his, and my, wishes that he should not be prescribed antipsychotic medication. I was not even properly consulted about the medications Jayden was being prescribed, I was just told that the ward team were going to give him something to calm him down. It was only after Jayden passed away that I learnt he was administered with Olanzapine and Haloperidol, during his few days of admission. This seemed to me to be prescribed without proper assessment of his presentation and clinical history, and without regard to my own expressed concerns about starting him so abruptly on these medications. I had given my view that I did not want him to be prescribed antipsychotic medication but clearly, I was not listened to.

238. The main reason I did not want Jayden to be prescribed antipsychotic medication was because I was very concerned how he would react to this medication. I was concerned it would make Jayden worse, before it potentially made him better, and I was very concerned that Jayden was not being sufficiently monitored or observed to support him with his deteriorating mental ill-health. I felt that he needed to be on constant observations, especially if he was going to be trialled on a new, powerful antipsychotic medication. This appears particularly important to me now, knowing that this new medication would likely have had a very strong effect on him and would have increased his dysregulation, at least for a while. I note for instance that the daily nursing entry for 22 October 2020, the day he was issued both Olanzapine and Haloperidol, refers to Jayden presenting as delusional and responding to unseen stimuli. I believe that his acutely psychotic presentation, which had escalated so quickly in the Linden Centre, was at least in part due to the prescription of these strong medications without adequate assessment or monitoring. I raised this issue with **C [I/S]** at the FEP Team when she called me on 26 October 2020, after Jayden had passed.

239. I was also concerned about antipsychotic medications being prescribed to Jayden when no one was taking into account my views that he could have ADHD. My understanding was and is that antipsychotic medication can completely inhibit dopamine levels in an individual, which creates issues for someone with already low dopamine levels, and forces them to seek that out by taking riskier actions.

240. The Medicine Prescription and Administration Chart at Finchingfield Ward was started on 19 October 2020. Dr **[I/S]** was the consultant psychiatrist recorded on the chart. In the Regular Medicines section, this recorded a prescription of Olanzapine, route: PO, dose: 5mg, frequency: ON, date signed: 20/10/20. Further down the chart, in the section "As Required –

ANTIPSYCHOTICS ONLY", it recorded Olanzapine but this is then crossed out. The details recorded in this section were: Drug: Olanzapine, Dose: 10mg, Route, PO, Indication: agitation (oral rapid tranquilisation), max dose: 20mg, Name in CAPS: [I/S] Date signed: 19/10/20.

241. The prescription chart also recorded the following under As Required – Other Medicines:

Drug	Dose	Route	Indicator	Max. Dose	Name in CAPS	Date signed
Promethazine	25-50mg	PO	Agitation	100mg	[I/S]	19/10/20
Lorazepam	1-2mg	PO	Agitation rapid tranquilisation	4mg/24 hrs		20/10/20
Promethazine	25-50mg	PO	Agitation	100mg		20/10/20
Nicotine Inhalator	15mg	INH	Smoking Substitute	Every 4o		22/10/20
Haloperidol	5-10mg	PO	Agitation	20mg		22/10/20

242. The boxes with Promethazine and Haloperidol prescriptions were crossed through in Jayden's records. I am concerned by this and the confusion this likely could have caused for anyone viewing his administration chart at the time. Equally, I am confused if this was crossed out after Jayden's passing, and the implication that could have.

243. Below is a summary of the medication Jayden was prescribed and/or given on a PRN basis which I have taken from the medical records:

a. On 20 October 2020, Jayden was reviewed upon admission by Dr [I/S] (GPST1), who was on-call. A new admission ECG was performed. The notes record, "*Patient is currently asymptomatic, no chest pain/SoB/collapse and obs aer stable. Has had Olanzapine 5mg on 19/10/20. History of drug use. Physical examination NAD. Heart sounds S1+S2+0. Discussed with on-call Tier 2 SpR Dr* [I/S]. *Advised to monitor this and not to give Haloperidol. If needed, can give Olanzapine or Aripiprazole if acutely psychotic. Also advised to give PRN Lorazepam as rapid tranquilisation if needed".* [sic].

b. Jayden's clinical notes for 20 October 2020 identified that Jayden "*has been very delusional responding to hallucinations"*. He was given 1mg lorazepam in the morning, then 1mg lorazepam and 50mg promethazine in the evening. The recommendation in this case note included for a medication review.

c. Jayden's clinical notes for 21 October 2020 record that Jayden appeared distressed in the morning and was given PRN 2mg lorazepam and promethazine to good effect. The case note history also identifies the recommendation for a medication review. During the night shift, the notes records that "*Jayden kept coming out of the isolation corridor, stating things were going to happen on the ward and that we were not safe. He was expressing himself with grand gestures and dance movements. Appeared distracted and finding it difficult to articulate himself*". He was given his prescribed medication of Olanzapine 5mg. No PRN medication was administered overnight. The recommendation in this case note included for a medication review.

d. The night-shift records for the early morning of 22 October 2020 record that Jayden "*was behaving bizarrely, dancing and waving his arms around theatrically, clicking his fingers, appearing suspicious of staff, distracted and to be responding to unseen stimuli."* Jayden managed to take his medication and later requested PRN. He was given PRN lorazepam 1mg and 50mg promethazine. The recommendation in these notes again includes for a medication review.

e. On 22 October 2020, the day shift nursing entry records that Jayden was "*presenting as irritable at the start of the shift, responding to unseen stimuli +++, making bizarre movements, delusional thoughts expressed and paranoid thoughts. He attended the canteen for breakfast and he was observed to try to pour tea over another patient, he was banging cutleries on the tray. He was escorted back to the ward and offered PRN medication*". [sic]. His case notes also identify a recommendation for a medication review.

f. On 23 October 2020, according to the clinical notes, Jayden was described as "*presenting as irritable at the start of the shift, making bizarre movements, delusional thoughts expressed and paranoid thoughts"*. He was therefore given 5mg of haloperidol and 1mg of lorazepam. The related recommendation was again for a medication review.

244. Despite there being a daily recommendation for Jayden's medication to be reviewed, I am not aware that this was ever done during his time at the Linden Centre. I fear that this reflects that staff may have also had concerns about what Jayden was being prescribed and the need for this to be reviewed and rationalised by the treating psychiatrist. I also have little confidence in the accuracy of the medication and prescription charts, in light of the record keeping errors and failures identified repeatedly in the PSII Report. The impression I have is that there was no considered or coherent oversight of Jayden's medication, and I remain unsure to this day what exactly he was being prescribed at the time of his death.

245. Similar to his time at The Lakes, I am concerned that whilst Jayden was detained at the Linden Centre, he was being chemically drugged as a means primarily of managing, rather than treating, his behaviours on the ward. Often it felt like Jayden was just being sedated, to get him to be lethargic and calm, rather than having any targeted treatment. I do feel that he needed sedation, because he was suffering from acute mental distress and was at high risk of absconding. However, it seems to me like this was the only plan of action, and it was not even sufficient to calm his thoughts or have sufficient stabilising effect.

246. I believe that Jayden's medication regime was seen as the easy way out for the treating staff. Rather than providing him with actual psychological treatment, they chose to medicate Jayden and then leave him to deal with the side effects on his own. I do believe that Jayden deteriorated as a result of these strong medications. For example, his notes described Jayden [I/S] [I/S], dropping medication, acting bizarrely, and generally losing functioning in his physical capabilities. I am concerned that I have seen no evidence of real monitoring of the side effects of the combination of medication that Jayden was placed on, especially the commencement of antipsychotics, nor any treatment plan. It does not seem sustainable to me, to try to sedate a patient with no other clear, longer-term plan to support him to get better. There is no evidence that any staff member was meaningfully engaging with him to assess or reassure him. Jayden was just given medication and left alone, in an unknown and scary place, with his harmful thoughts.

247. The PSII Report raised concerns regarding the prescription of medication. It identified that, as above, on 20 October 2020, the Responsible Clinician prescribed 10mg olanzapine by mouth, to be taken every night. However, Jayden's ECG on admission was slightly abnormal, so only 5mg was prescribed pending a repeat ECG. The Responsible Clinician intended for the dose to be increased to 10mg if the second ECG was satisfactory. This second ECG was delayed, due to apparent shortages in medical staff, until 22 October 2020. Whilst this was normal, Jayden's dosage remained at 5mg throughout, rather than being increased to 10mg as intended following the ECG. The PSII Report therefore criticised the failure to adequately and promptly review Jayden's Olanzapine prescription and adjust it in response to his clinical needs. Further, that the systems and processes governing this process were "*not robust*" in respect of the follow-up and allocation of the psychiatrist's treatment plan for the repeat ECG.

248. My view is that Jayden ought not to have been so strongly medicated. However, I am also concerned that, once he was medicated, this was not sufficiently monitored and overseen. The doctors overrode mine and Jayden's wishes in terms of medication and then proceeded to not give due regard to the need to closely monitor his clinical response and any emerging side-effects. As I have already set out, the PSII Report also identified that Jayden ought to have been on a higher level of observations at the time, which I consider to be particularly significant in light of the potential side effects of such strong medications.

Decision to Discharge and Continuity of Care and Treatment in the Community

Discharge into the community

249. Further to what I have already said above, regarding Jayden's discharge to the community from The Lakes on 28 September 2020, I have the following grave concerns regarding this discharge decision:

    a. The way in which the discharge decision was conveyed to me. I had believed I was simply attending a ward round. When I arrived, the decision had already been made, and was presented to me, without notice, as the agreed plan. My views on discharge were therefore treated as irrelevant.

    b. The lack of support given for Jayden's accommodation arrangements upon discharge. The ward team just assumed that Jayden would come home with me, despite him being an adult, and the concerns I expressly raised that I could not care for him safely at home. The fact that I was evidently struggling, and was so worn down by caring for Jayden, alone, appeared irrelevant. Nor did the fact that Jayden was also technically homeless seem to register as a concern for the clinicians discharging Jayden, far less so as a problem that they were required to fix.

    c. No discharge plan was given to me or any documentation setting out ways to manage and support Jayden in the community. I was just told to wait to hear from the relevant community team, though I was not even told which team this was.

    d. The whole process felt incredibly rushed, abrupt, and unplanned. We were given very little information about the process for discharge. None of the clinical team even sat down during the meeting when I was told Jayden was being discharged.

    e. Jayden's notes record that he was being discharged for further assessment in the community. Given that the very point of sectioning him had been to assess him, this was a clear sign to me that the discharge was very premature.

    f. On 17 September 2020, 2 days after Jayden was admitted, I called the ward raising my concerns that Jayden was likely to try very hard to convince staff that he was ready for discharge, and that I felt it was really important that they understood he was very unwell, but he knew how to mask this. I asked, at that early stage, to be involved in any discharge planning when the time did come, as he would not be able to return to the family home. This is recorded in the clinical records that day. Unfortunately, my pleas were not listened to.

250. All we were given when Jayden was discharged was a leaflet with phone numbers for various services, 3x 2mg Lorazepam for Jayden to take 'as needed' over 3 days (relying on Jayden's judgment of when he needed this, when he was plainly not capable of having this degree of insight), and a letter to the council regarding his homelessness (which I address further below).

251. I am very concerned that Jayden's discharge was so rushed because they did not want to keep him on the ward any longer and risk him absconding. Staff were well aware of Jayden's history of running away and I had expressly reported to staff, days before, that that he was talking about absconding. I also now understand that, shortly before Jayden was admitted, a patient at The Lakes had taken her life whilst on unescorted leave.

252. Overall, I remember a feeling of promise when Jayden was admitted to The Lakes. I was told Jayden would receive psychotherapy; that he could stay there up to 28 days to be assessed and treated; that he would get therapeutic support in that time; that I had made the right to decision to fight so hard to have him hospitalised; and that he would have help finding housing when he was ready for discharge. This was not at all the experience we had. None of these promises were delivered on. I felt so desperate, and betrayed, when Jayden was discharged suddenly only weeks later.

253. In the car home, after he was discharged, Jayden told me that his treating team had told him he needed to stop taking MDMA, because if he did not, he would end up back in The Lakes and would be even worse. I found this statement insulting and confusing. Jayden had not received any care or support regarding his drug and alcohol addictions whilst in The Lakes. Instead, his substance misuse issues were just used to blame him for being there and for being unwell. He received no advice or treatment beyond being told to stop taking drugs.

Homelessness

254. Before Jayden had gone into The Lakes, I had been in touch with a woman working with the Peabody Trust to get some advice for myself. I raised with her that Jayden was struggling with his debts, as well as applying for PIP and housing. She opened a file to assist Jayden. The first time I visited Jayden in The Lakes, she called to speak to Jayden to get information to help with his housing application, however Jayden was not well enough to speak with her directly. She asked us a few questions which we answered, but I do not remember that anything further materialised from this.

255. At the ward review meeting on 28 September 2020, upon being told Jayden was being discharged, I raised with the Responsible Clinician, **Dr B**, that I did not know what to do to support Jayden with his housing. He told me that they had considered this and prepared a letter to the local council that I was told would get Jayden housing. The letter was given to me already sealed in an envelope, so I did not review it in the meeting. I remember feeling relieved that this

documentation would help as it came from Jayden's treating inpatient team.

256. The letter that **Dr B** provided was addressed to the Housing Department at Chelmsford City Council, and read:

> *I am writing to you regarding the above named patient who was admitted to Gosfield Ward on 15th September 2020. Mr Booroff is currently homeless. Given his mental health history he could become vulnerable if he does not have a place to stay which could have an impact on his mental state and physical wellbeing.*
>
> *His discharge diagnosis is that of personality disorder with substance misuse.*
>
> *He is fit for discharge today and has therefore been discharged from Gosfield Ward. We would therefore recommend that his case be considered as priority and he will require emergency funding.*

257. On 29 September 2020, I called the Housing Department with Jayden. The lady I spoke to explained that she needed evidence of Jayden's emergency priority need. I emailed her a copy of the letter. I recall that she called me back and said she had never seen anything so ridiculous and that she could not do anything with that letter.

258. The lady at the Council asked me if Jayden was homeless now and I confirmed that he was. While I was on the phone Jayden was acting very erratically, wondering in and out of the house, and it was very hard to look out for him and speak to the woman at the Council at the same time. I did receive a call back from the Council, confirming that they could offer Jayden a space at accommodation called the Oasis Hotel in Harlow. She said that I had one hour to make a decision, given that it was emergency housing. I went online to review the proposed placement, and remember being very concerned. The reviews said that the hotel was full of 'crackheads' and lots of people with unsupported mental health issues. I remember thinking that this was clearly not an appropriate placement for Jayden, being a very vulnerable adult who needed an intensive level of care and support. We turned down this accommodation and, as a result, Jayden was placed on the waiting list and no longer considered in priority need.

259. The only option left, therefore, was for Jayden to stay living with me, even though I was deeply concerned for his safety, and that of myself and my other children. I still feel incredibly disappointed by The Lakes for forcing me into this position. There was absolutely no planning from them as to his accommodation arrangements, despite recognising his acute vulnerability if he was to be left homeless.

Treatment in the Community

260. A further concern I have regarding Jayden's treatment in the community, beyond what I have stated above, relates to the approach to his compliance with treatment. Jayden was regularly referred to as being 'non-compliant' or 'not engaging' with his community visits and contact. But Jayden had lost connection with reality; he thought that he had powers to get him to the next realm and did not accept, the majority of the time, that he was unwell. It is not clear to me how he could have been expected to be 'compliant' with treatment in those circumstances. This seemed to be a big barrier to his getting any substantive psychiatric treatment or therapy in the community. It felt like it was assumed that Jayden had capacity to understand the importance of compliance, whereas in reality he often did not even know he needed help.

261. For example, when Jayden arrived back home after discharge, the FEP Team were trying to contact him to arrange an assessment. However, Jayden was not answering his phone. He would get confused when he saw an unknown number and often did not know who he was speaking to when he did answer. The FEP Team continued calling him for days, before calling me to arrange the assessment. This was not 'non-compliance', but rather a direct consequence of his deteriorating mental health. I believe that this mischaracterisation of Jayden's behaviour informed the serious issues in communication and treatment we experienced with the FEP Team. As I have explained above, no initial assessment was ever completed in respect of Jayden, meaning that he did not receive any community treatment or support plan during his period in the community in October 2020, following his discharge from The Lakes.

Concerns and complaints; the quality, timeliness, openness and adequacy of responses to concerns

262. As above, I routinely called the community mental health teams (when Jayden was in the community) and the wards (when he was an inpatient) to raise my concerns about Jayden's deteriorating mental state. There were many times, as discussed above, that I was seriously concerned for Jayden's safety and needed the relevant clinical staff to understand just how high risk he was of self-harm and/or escaping. As described above, I encountered various difficulties in these attempts at communication. This included being unable to speak to the relevant teams, and the absence of having one designated person to speak with. I consistently felt like I was repeating myself to different members of staff and giving important information about Jayden over and over again into the ether. I have learnt since his passing that a lot of ward staff were often unaware of Jayden's needs, risks and other key information that I had provided to different staff members. This was either because the information was not handed over or updated in his records, or because staff did not review his records before engaging with Jayden.

263. When Jayden was admitted to The Lakes and to the Linden Centre, I was sent a letter informing me that I was his Nearest Relative and that Jayden had been detained under the MHA 1983. A leaflet was

also enclosed to this letter, addressed to the detainee patient rather than the Nearest Relative, with information about appealing a detention. I do not remember receiving this at the time, but have found the letters and leaflet in my records.

264. Throughout Jayden's two admissions, I was fearful of raising concerns or complaints, out of fear this could impact his treatment. I did not know the specifics of what was happening with Jayden inside the wards, and I did not want to cause any problems for him, especially given that it already appeared to me that Jayden may have been being poorly treated and mocked by staff at The Lakes.

265. I have explained above that the first time I visited Jayden in The Lakes, when I was waiting for him in reception, I was asked to complete a feedback form regarding the service. This felt more like a form I should have been asked to complete once Jayden had been discharged. Again, I did not want to put anything too negative in there in case it impacted his care and treatment. I did raise my concerns about the phone number on the ward changing, as it was very difficult for family to get in touch with patients. I never received any follow up to this.

266. When he was at The Lakes, Jayden sent me a text message saying: "*I will be making sure I get my word in after I leave!*". He was deeply troubled by what he saw on the ward, in respect of staff treatment of patients, and wanted to make sure that something was done to improve patient safety on leaving.

After Jayden Passed Away

Information about the process following Jayden's death

267. On 26 October 2020, C at the FEP Team called me to discuss Jayden's passing. I was very upset and asked how it was possible for Jayden to have absconded from a locked unit. C said she could not answer this for me, and told me to write any questions I had down as there would be an investigation as this would be classed as a serious incident. C told me my questions could be asked of the relevant persons investigating the serious incident.

268. By this time, I still had not had any correspondence or offer of condolences from anyone at the Linden Centre.

269. [I/S] [I/S]. C reached out and offered to act as liaison for me in respect of the PSII process. I think she did this out of kindness, rather than this being part of her role.

Support

270. Jayden was due to receive four therapeutic sessions (I do not know what specifically) under the FEP Team that he never received nor were arranged. After he died, I was offered to use these

sessions instead for therapy regarding his loss. I remember feeling very conflicted by this. I knew I needed support, but I felt extremely guilty taking sessions that were meant for Jayden. I felt like I was stealing from him. I recall these sessions also feeling more like they were being used by EPUT to gather information about what happened to Jayden, rather than focusing on me and my health. My trust in EPUT had rapidly declined by that stage, and I remember having an overwhelming feeling that they were trying to cover up for themselves, because they had done something wrong.

271. Whilst Jayden was unwell, I was also under secondary mental health services. I had a support worker and a CPN. The CPN was only allocated to me a few days before Jayden passed away. I got on very well with both by CPN and Support Worker at that time. I was also put under the Home Treatment Team after Jayden passed away. The support I received under this service was erratic and did not meet my needs.

272. I made a complaint concerning my own care from EPUT on 16 August 2023. This mostly related to my concerns about my support worker, **[I/S]** The complaint was responded to on 12 April 2024. I would like the Inquiry to read this complaint outcome in full.

273. The complaint response concluded by finding that:

> *"On review of the available evidence, I feel there is a broader issue to be addressed, and that is the service's handling of your care, and their responsibility to ensure that a robust care plan was established and being followed. In addition, it is reasonable to expect that contingency plans should have been in place to support you if* **[I/S]** [a social worker involved in my care who continuously cancelled my appointments] *was unable to – which, under investigation, is not evident.*
>
> *[…..]*
>
> *Having concluded my investigation, I have found that there was a significant decline in contact after March 2023 up until August when you submitted your complaint. As I have previously detailed in my response, there were clearly issues with your care coordinator being able to fulfil her duties. I feel these issues should have been picked up by senior staff within the service, and an appropriate plan put in place to provide the support needed. On behalf of the Trust I extend my sincere apologies for these failures."*

274. As a result of the complaint outcome, I was allocated a new care coordinator. I was also offered a mindfulness skills course online, in a group setting, which I did attend.

275. When I saw the outcome of my complaint, and the numerous failings that were upheld, I remember feeling a deep sense of grief and shock that there were similar failings to those that contributed to Jayden's death.

276. In August 2024, I received six sessions to assess me for EMDR therapy. During these sessions, I was told that I would get monthly phone calls whilst I was on the waiting list, to check in on me. I was later told these calls would be every two months. The last call I received was in February 2025.

277. I am still under EPUT's mental health services, though I have had very little by way of substantive support. I have seen no improvement in the care I have been receiving since my complaint. My support worker visits me sporadically and offers little to no help when I do meet with her. I am still waiting for EMDR therapy, and have been told that I am 8th on the waiting list. I have not had my medications reviewed for a very long time, and feel alone in managing these. Overall, I feel extremely trapped in falling under EPUT's remit of care. EPUT has control over my ADHD medication, and has been dangling the carrot of EMDR therapy for years, so that I feel I cannot walk away and risk going to the bottom of another EMDR waiting list in another service. For example, I asked to be transferred to Hertfordshire's care, after the statutory phase of this Inquiry was set up, but I was told by my support worker that that I would lose my place on the EMDR waiting list if I did transfer across.

278. I put in a complaint to the ICB in June 2025 regarding these issues. In this complaint, I questioned whether my participation in the Lampard Inquiry was negatively impacting the 'support' I was receiving. In response to this complaint, I received a letter from the EPUT psychology team telling me I am 8th on the waiting list, but they could give no indication of timeframes because of staff shortages and various other factors. On 12 June 2025, I also received an email form the Specialist Mental Health Team asking me to fill out a Recovery of Quality of Life 10 Questionnaire. I was feeling very low when I completed this questionnaire, so the results showed that I was under high distress at that time. I have not however received any follow up, further to completing this questionnaire, nor updates from the psychology team, responsible for the EMDR therapy, to date.

279. Being required to engage with the service that I hold responsible for the death of my son is extremely difficult. I cannot trust staff from EPUT. Since Jayden has died, I have continued to see, time and time again, the same issues arising around record keeping, uncaring attitudes, high staff turnover, the gaslighting and blaming of patients, miscommunication, and dangerous practices playing out in the care (or lack thereof) that I am receiving.

Involvement of British Transport Police ('BTP')

280. BTP undertook an investigation for the coroner's office. This was submitted to the coroner on 20 February 2021, and was completed by [I/S], the Coroner's/Fatality Investigator. I was and am deeply concerned and disappointed by the investigation carried out by BTP, and the approach and attitudes of the investigator, [I/S]. The investigation concluded by providing only a general summary of the circumstances relating to how Jayden ended up on the railway

tracks.

281. My concerns regarding the investigation itself related to the limited steps undertaken by Mr [I/S] in conducting his investigation. This includes the following examples:

a) Mr [I/S] did not question or interview the ward security guard; my friend who was involved in the search for Jayden; and/or staff at the Lakes.

b) Mr [I/S] did not take an account or statement from me, in relation to the steps I had taken to search for Jayden.

c) [I/S]

d) Jayden's friends told me that they felt coerced and bullied by Mr [I/S] to say certain things in their statements regarding Jayden's drug addictions. They felt so strongly about this that they provided separate statements to the inquest, and asked for those to be relied upon, rather than the statements they had given to Mr [I/S]. They told me that Mr [I/S] was very focused on Jayden's drug addiction, saying things like "*so he liked to party then*", when discussing his addictions.

e) Mr [I/S] did not obtain local CCTV and/or footage from the Ring doorbells Jayden would have passed after he left the Linden Centre.

f) I had to locate Jayden's colleague who saw Jayden the night he escaped, and Mr [I/S] only spoke to him very briefly on the phone.

282. Overall, I generally felt that this was a wholly inadequate, lazy investigation, with the outcome already decided in advance. There was no interest in investigating any details that might have assisted myself, my family, or the Coroner's Court, with a better understanding of Jayden's final moments. As a mother, you want to know what your child's last moments were. I needed to know how he came to be so far away from the hospital on the train tracks. I needed to know how he got there. I felt that I had to push for any of these details to be investigated and there are still so many questions that I do not know the answers to, which is devastating.

283. I found that Mr [I/S]' attitude to the investigation was callous and lacking in empathy. Even when speaking with me, he appeared to be very focused on Jayden's substance misuse issues. He left me with the impression that it was a real chore having to investigate Jayden's death, and that it was a process to go through only to tick boxes. It seemed to me that Mr [I/S] viewed Jayden as a violent, drug user who was not deserving of help. that I never met him in person. He came to Chelmsford once, and spoke briefly with Jayden's step-sister, but he never made any effort to meet with me in person.

284. The distinct impression I had of Mr [I/S] and his views towards completing this investigation, was that he felt Jayden was a violent, drug user who was not deserving of help.

285. I also was not offered a family liaison officer through this investigation process, which I found very difficult. Mr [I/S] demeanour felt harsh and subjective. For example, he described the footage of Jayden tailgating and running from the Linden Centre using biased and strong language such as Jayden '*shoving'* the HCA out of the way and being very '*sneaky'*, '*like James Bond'*, in his movements. He did not even mention the HCA's failure to look behind her, or check that the doors were closed. It was all Jayden's fault, was the impression he gave me. He had no empathy and appeared to have no understanding of mental health illnesses and view what happened as solely Jayden's fault. He did not seem appropriate in any way to be carrying out this investigation, and to be speaking to me about it. As above, he also left me with so many unanswered questions. No one explained to me whether the public would have been able to see Jayden's body after he was struck, and if this could be posted on social media. If I had had a family liaison officer, I could have had someone who could work through these concerns with me, in an empathetic and compassionate way.

Involvement of Essex Police

286. I had no contact with Essex Police about Jayden, following his death. No one visited or spoke with me about the steps they took in searching for Jayden, the decision to downgrade him to medium risk, or their post-incident investigation report. No one from Essex Police even spoke to me or visited me on the night Jayden absconded. I was only visited once, by a police officer, in relation to my complaint about the police investigation, which I had raised before Jayden's inquest.

287. The only contact I had with Essex Police after Jayden's passing, was when my family reported me missing after I ran out of the house after Jayden's funeral. When I returned home, there were lots of Essex Police officers in my house, and appeals for me had been made on social media. I felt so betrayed that they had reacted so seriously and quickly when I went missing, but had not taken any of those steps for Jayden, who they knew was so vulnerable. From the PSII Report, for example, I learnt that Essex Police only requested to review the ward video footage after a body had been found on the railway tracks, as they wanted to identify Jayden. I believe that there was a worrying level of complacency shown by Essex Police, in relation to patients who absconded from the Linden Centre. It seemed to me that, because it happened so frequently, and patients would often return unharmed, when Jayden was reported as missing, this was not taken as seriously as it should have been. Instead he was treated as 'just another patient who went missing from the Linden Centre'.

288. On 15 June 2021, I called 101 to find out what action had been taken by Essex Police the night Jayden went missing, as I still had not been told by anyone. This was when I was told that

Sergeant [I/S] had downgraded Jayden's risk level to "medium risk, non-priority". It was also recorded on the system that Jayden was "*in and out of mental hospitals, heavy drug use, phone taken away due to violent texts*". I felt this painted a very inaccurate, violent image of Jayden which informed the mis-categorisation of his risk level. It was emotive, subjective and biased language that showed Sergeant [I/S] 's prejudices.

289. At Jayden's inquest, I also learnt that Essex Police did not liaise with BTP when Jayden went missing. As a result of this failure to share information or work with BTP, a crucial opportunity was missed for BTP to take relevant steps to activate the marker placed on Jayden's name in their systems regarding his risk around train stations and railway tracks.

290. I subsequently complained to the IOPC about the actions by Essex Police in respect of searching for Jayden. There was a significant delay in the management and review of this complaint. When it was finally considered, on 23 May 2023 the IOPC confirmed that my complaint would be sent back to Essex Police for local investigation. I do not understand how individuals are meant to be able to trust a police service reviewing its own actions and effectively marking its own homework. I felt distinctly let down by the IOPC in its decision to remit my complaint back to the very force I was complaining about. I later found out that this decision was a clerical error, and that the IOPC should have undertaken this review. Whilst the IOPC apologised for the error, they explained that, because Essex Police had begun the review, the IOPC could no longer intervene.

291. The complaint investigation conducted by Essex Police was flawed, producing a report which was full of inaccurate information and which made no critical findings. I then appealed this outcome to the IOPC, which upheld all of my complaints. This included my complaint that Essex Police had not considered the discrimination element of my complaint. As a result of this, the IOPC required Essex Police to re-review their investigation. This felt like a ridiculous and convoluted process of the complaint going back and forward between the IOPC and Essex Police.

292. Essex Police's second investigation was just as poorly conducted as the first. The complaint outcome was sent to me with no warning or advance conversation. I had already discussed with the complaint investigator that I was very traumatised and affected by Jayden's passing. I also made clear that I did not know the full injury detail regarding Jayden's death, as that is not something I ever wanted to know. I was reassured that the complaint outcome would be discussed with me first and appropriately redacted to avoid me learning of any specific details concerning Jayden's injuries. However, this did not happen. Instead, the complaint outcome was emailed to me and sat in my junk folder for weeks until I found it. I started to read it but then saw it had not been at all redacted. I forwarded it to my solicitors immediately, and then deleted it, so I would not read anything distressing that I could not cope with.

293. I had also made a Subject Access Request for the police records concerning all of their relevant

contacts with Jayden. Again, I requested that this did not include any distressing information about his injuries. This was sent to me again in entirely unredacted form including such information.

294. Ultimately, I completely ran out of energy to take things any further with the police. It was clear to me that Essex Police had no interest in learning any lessons from Jayden's death. They had no interest in reflecting on their actions, and identifying if anything could or should have been done differently. The whole process was completely demoralising retraumatising, and lacking in any level of care or compassion. It also created further trauma, as I learnt new distressing information about Jayden's death. I had worked so hard to avoid learning about this until then, as it is not how I wanted to remember my son. With one careless act, the police investigator managed to undo all of this and cause me irreparable harm.

Quality of Investigations Undertaken or Commissioned by Healthcare Providers

295. After Jayden died, EPUT commissioned a Patient Safety Incident Investigation Report, by Lead Investigator H This was completed on 30 December 2020. The investigation team consisted of:

    a. Investigation Commissioner/convenor: Natalie Hammond, Executive Nurse, Executive Directors EPUT.

    b. Lead investigator: H, Patient Safety Incident Investigation Advisor, Patient Safety Incident Management Team, Nursing Directorate, EPUT.

    c. Subject matter expert: Dr [I/S], Consultant Psychiatrist, Basildon Mental Health Unit, Inpatient Mental Health, EPUT.

296. I have summarised below the key findings and recommendations of the PSII Report. These have also been referred to at various points earlier in my statement. I consider it is very important for the Inquiry to read this report in full. I understand that this has not yet been requested by the Inquiry Legal Team. I request permission to provide a copy of this PSII Report to the Inquiry.

297. I agree with all of the concerns identified by the PSII Report. The PSII Report identified multiple Care Delivery Problems which it defines as points in the timeline at which: "*something happened that shouldn't have happened; or something that should have happened didn't. These system weaknesses will have two essential features a) care or service deviated beyond safe limits of practice b) the deviation had at least a potential direct or indirect effect on the eventual adverse outcome for the patient.*" (emphasis added).

298. I do not however feel that the report went far enough. I believe that Jayden's death was entirely avoidable. I also have further concerns about Jayden's care which were either not covered in

the PSII Report at all or sufficiently. I have detailed these concerns throughout my statement, and I will not repeat them here.

299. After the report was completed, Mr H offered to meet me to take me through the findings. I met with him. At the beginning of the meeting, I showed him a video montage of Jayden, in memorial. I had had so many experiences of Jayden being completely dehumanised and blamed, both whilst alive and following his death, that I wanted to ensure that he was now treated with dignity and respect. Mr H 's reaction to the video really surprised me. He was clearly very upset and affected watching this, becoming visibly emotional and tearful. I was also very surprised by how thorough the report was, and how much sensitivity Mr H showed when discussing the findings with me. I am very grateful to Mr H for the care and compassion he showed to me personally, and in respect of the conduct of this investigation. I believe that his approach took me so much by surprise, because this was the first time, since Jayden's death, and even before, that anyone had shown Jayden and me such empathy and compassion. Mr H made one of the first and only apologies and offers of condolence that I felt someone from the Trust actually meant. His considerate approach of empathy and care gave me confidence in the report process, that it had been conducted thoroughly, candidly and fairly. This in turn meant that I actually had some faith that its recommendations might be acted on. It made me realise how rare it had been for me, and Jayden, to be shown compassion and kindness by EPUT. I am very grateful to Mr H , and feel that if others within the Trust could act as openly, candidly, and kindly as he did, that the public could begin to rebuild its faith in EPUT.

Decision-making regarding Jayden's prescription

300. The PSII Report firstly identified concerns with decision-making regarding Jayden's prescription. It identified a key care and service delivery problem as follows:

> *"On 20/10/2020 The Responsible Consultant (RC) intended for a dose of 10mg olanzapine (antipsychotic medication) by mouth to be taken every night. However, Mr B's electrocardiograph (ECG) on admission was slightly abnormal so whilst awaiting repeat ECG, 5mg was prescribed. The RC intended for the dose to be increased to 10mg if the repeat ECG was satisfactory. The second ECG was delayed until 22/10/2020, it was satisfactory but Mr B remained on 5mg throughout his whole admission instead of 10mg. The systems and processes were not robust; there was no follow up on why the ECG had not been competed at an early stage and there was an unintended delay to complete the ECG. The ECG was completed on 22/10/2020 and although additional medications were prescribed over the course of his four-day admission the RC's intention for 10mg olanzapine to be prescribed was not actioned."*

301. The PSII Report found that this failure was contributed to by multiple areas of concern, including:

a. Medical leadership taking too passive a role rather than proactive approach to the management of patients' needs.
b. Staffing levels and skill mix, which was particularly affected by the Covid-19 pandemic, and that two junior doctors at the time who were not able to come into face to face contact with Jayden pending a negative Covid-19 test result, which limited their ability to follow up on physical health investigations.
c. Lack of shared understanding between the Responsible Clinician and senior ward doctor.
d. Weaknesses in the transfer of communication, establishing a shared plan of care and the allocation of tasks required to deliver optimal care.
e. Ineffective ward handover and poor timekeeping.
f. Lack of a *"shared mental picture*" of what needed to be done, when and by whom, due to poor communication, understanding of the sharing of roles and responsibilities, and staffing levels.

Reduction of observation levels

302. A second care delivery problem identified by the PSII Report was in respect of the decision to downgrade Jayden's observations on 21 October 2020, as already discussed above. The full findings of the PSII were as follow:

> *"At 19:00 on 21/10/2020 Mr B's level of engagement and observations were reduced from level 2 to general observations. This meant that rather than having engagement and observation by a staff member at a minimum of four occasions at random times within every hour, the engagement and observations would be a minimum of once per hour. The manner in which the levels of observation were changed did not follow the detailed plan made for reducing the level of observations by Mr B's named nurse and were not in accordance with the expectations of Trust policy CLPG8 - Engagement and Supportive Observation Procedure. In the context of planning to abscond rather than it being a spontaneous act, if Mr B had remained on level 2 engagement observations until the day of the incident the heightened level of engagement leading up to the incident may have given opportunity to have detected behaviours such as unusual interest in exit routes which may have indicated impending attempt to abscond."*

303. The PSII Report found that this failure was contributed to by the following factors:

a. Uncertainty amongst staff around roles, responsibilities and accountability.
b. Failures by staff to comply with the Engagement and Supportive Observation Procedures.
c. Over reliance on nursing staff to manage observations.

d. Risk assessments and plans regarding Jayden's levels of observations were not followed.
e. Staff misinterpretations of the acceptable circumstances in which the level of observations could be reduced.
f. Not all clinical risk training had been attended at the right level.
g. The 'SBARD' method of communication was not correctly understood by some staff.
h. Missed opportunities to plan ahead, and document, for when levels of observations could be reduced.

Absconsion

304. A third care delivery problem identified by the PSII Report was the fact of Jayden's absconsion, the report finding that "*Systems and processes at the time didn't prevent him leaving when they should have done"*. The report identified the following factors as contributing to this over-arching failure:

a. Patient safety incident data was not shared widely as it could have been and there were missed opportunities to learn from patient safety incidents.
b. Design of ward areas and security features (including absence of intercom systems and physical features such as airlock systems, as I have explored above).
c. Nursing staffing levels were at establishment. However, if the incident had happened in the daytime, there may have been an increased chance that video footage monitors in the ward office may have detected the abscond.
d. Ward doors and lack of airlock systems were not conducive to prevent absconding.
e. Inconsistency of documented risks and lack of effective communication to staff on risks. Jayden's risks of absconding and impulsivity should have been documented on the SBARD notes.
f. The shared responsibility of security risks between the ward, service and estates department was not fully appreciated, with each seeming to suggest the other was responsible for identifying the necessary security works required.
g. A variety of processes across different sites contributed to the staff member Jayden tailgated not using a spare pinpoint, which would have avoided the need for her to leave the ward which gave Jayden the opportunity to abscond.
h. There had been some security factors in effect at the time, such as the outer, sliding doors being locked at 21:00 and the presence of security guard staff. These processes may have "*cognitively biased"* staff to accept these measures as adequate.
i. Evidence reviewed suggested that the staff member Jayden tailgated was late to the start of shift, which may have led to over-focus on getting into work without delay, resulting in relapse in checking the doors.

305. In respect of factors which the report found to be directly causative of Jayden's death, these related to the system and individualised failures concerning the circumstances of his

absconsion, namely the staff member's actions in leaving the ward to retrieve her pinpoint alarm, the environmental and security weaknesses on the ward, and the subsequent missed opportunities to prevent Jayden absconding.

306. As I have already addressed elsewhere in my statement, the report also made various other critical, albeit non-causative findings. This included the failure to properly assess and identify Jayden's psychotic illness at The Lakes, issues with record-keeping, the failure to finalise Jayden's 72-hour care plan, and failures in ward communication processes with family members.

307. The PSII Report made fifteen recommendations in total. I have set these out in full, as I believe it is important for the Inquiry to appreciate the breadth and significance of the issues raised:

(i) Addition of an 'airlock' time delay system at the Linden Centre to ensure that one door cannot open before the other is closed.

(ii) The fitting of a security video intercom to the main double door set at the Linden Centre.

(iii) For the Trust to send out a security message alert regarding risks of tailgating.

(iv) For Trust policy RMPG05 – Pinpoint Operational Procedure to be available on the intranet. It was not available at the time of Jayden's absconsion.

(v) For the Trust to review how Datix incident data (in particular near-miss data) effectively influences its governance processes to reduce the risk of absconding and how it is shared with interrelated stakeholders such as the estates directorate.

(vi) For the Trust to undertake a detailed longitudinal history, with multiple sources of information, alongside stringent adherence to diagnostic criteria, before making a diagnosis of personality disorder where that of an acute mental illness may be more relevant.

(vii) The ward should strengthen local arrangements for junior doctor cover alongside robust medical staffing procedures and monitoring of leave and other absences so that systems could be alerted for alternative arrangements to be made.

(viii) MDT meetings and ward reviews must be strengthened by implementing a programme of daily safety huddles/management rounds between the RC and nurse in charge to improve situational awareness and optimise patient outcomes. This should include the requirement that "*at least once per day, the medical and*

nursing leadership should update themselves on the level of observations to which all individual patients are being nursed on".

(ix) The service should make clear the expectations regarding Level 2 observations, and in particular that they were not only to be applied for infection prevention and control reasons.

(x) The Trust to make clear to staff whether or not the SBARD nursing notes were expected to document current risk, recent risks, or both. This was due to lack of clarity and confusion amongst the staff on this.

(xi) During admissions when the named nurse is allocated, a co-worker should also be allocated to cover alternative shifts to the named nurse. This was due to the failure by the staff to create a full care-plan for Jayden due to his named nurse being on leave.

(xii) The ward to ensure it has effective communication processes to recognise risks and act upon them appropriately.

(xiii) Training to be provided to staff to avoid copying and pasting of SBARD notes.

(xiv) Examples of good practice to be shared with staff to replicate the same.

(xv) The ward to strengthen its processes in recording photo identification and description of clothing for those patients at risk of absconding.

308. EPUT responded to these recommendations in an Action Plan that was disclosed in the inquest.

Other investigations or legal proceedings

Care Quality Commission (CQC)

309. On 5 January 2021, the CQC wrote to me explaining that they had conducted a surprise inspection of Finchingfield Ward on 29 October 2020, which was conducted in response to Jayden's absconsion and death. The CQC also returned to the ward on 6 November 2020 to review Jayden's records and watch the CCTV footage. The CQC confirmed that their report with their findings would be published on 14 January 2021. Their letter highlighted the investigative and prosecutorial powers the CQC had. Their letter also indicated that they would be reviewing Jayden's case to decide whether they would use their investigative or prosecutorial powers to take action. I remember feeling very reassured by this letter, and hopeful. To me, it was very clear that Jayden absconded due to EPUT's failings and neglect, and therefore I was relieved to see that action would be taken against them.

310. After receiving this letter, I believe I called the CQC directly to speak to the investigator to understand the process. I do not recall speaking with anyone, and I have a note to myself saying that, after 7 weeks, I still had not heard back from anyone.

311. I then received a letter from **[I/S]** Inspection Manager at the CQC on 20 May 2021, confirming their decision not to investigate Jayden's death further. She explained that: "*whilst failures have been identified by our review of the evidence and in the Trust's internal investigation, the Commission has determined that Jayden's death did not result from these failures. As such, question 2 is not satisfied".* The corresponding Question 2 was: "*Does the information about the specific incident suggest the harm sustained was avoidable and may have resulted from a breach of a prosecutable fundamental standard?"*. This letter further stated that the CQC found no causal link between the Trust's failures and Jayden's death sufficient to progress an investigation.

312. I attach a copy of this correspondence from the CQC at [**Exhibit MB2**].

313. I could not understand how the CQC could find no causal link between the Trust's failure to keep Jayden safely detained on the ward, and his death within hours of his absconsion from the Linden Centre. Jayden died because he was allowed to leave the Linden Centre, whilst an acutely unwell inpatient detained under section. Despite this, he was able to follow a member of staff through three set of locked doors and then run through a set of automatically opening doors out of the ward. There is clearly a causal link between the circumstances which enabled Jayden to abscond from the ward and his death hours later. The PSII Report similarly identified this causative link.

314. There was no information in the letter regarding any right to appeal or challenge the CQC decision. By this time, the inquest process had begun for Jayden and I was in the depths of significant grief at Jayden's loss. I did not have the ability or strength to take this further at that stage. I did call the CQC back, to question their decision, but was not provided with any clarification. I was only given information about their decision making processes in this call. I was left to understand that their decision was final and there was little that could be done about this.

315. I was really upset by the CQC's decision. I recall being concerned that this decision was reached because the PSII Report had identified Care Delivery Problems, which may only have had a potential impact. I had always, and do still, believe that Jayden's death was avoidable.

316. The CQC's decision not to investigate further due to there being "no causal link" was deeply disturbing, confusing, and frustrating to me. This was especially so when set against the background of factors that were found contributory to death in the PSII Report and by the jury in Jayden's inquest. I would like the Inquiry to investigate why this investigation was not progressed by the CQC, and whether it ought to have been. I also want the CQC to take action now, to

investigate a potential prosecution. This decision has always been on my mind; it has stayed with me throughout all the other investigations, processes, and legal proceedings I have been through. I want the CQC to exercise their prosecutorial processes, so that EPUT is held accountable for my son's death. If the CQC does not take this step, it begs the question: what is the point in having these powers if they are not going to use them? I want to better understand if and in what circumstances the CQC has ever used these powers in respect of mental health inpatient care.

Inquest

317. Jayden's inquest was opened on 17 November 2020. The final inquest hearing took place on 14 – 25 November 2022 at Essex Coroner's Court. The hearing was before a jury and heard by HM Area Coroner ('HMAC') Sonia Hayes. I had legal representation at this inquest. The interested persons were: myself, EPUT, Essex Police, BTP, and the security guard on shift the night Jayden absconded.

318. There were four pre-inquest review hearings ('PIRH') leading up to the final inquest hearing. The first PIRH was before Senior Coroner Lincoln Brookes, with the following hearings all before HMAC Sonia Hayes.

319. At the conclusion of the inquest, on 25 November 2022, the jury returned the following narrative conclusion, which was highly critical of the care provided by EPUT and identified a number of inpatient failures as contributory to Jayden's death:

"Jayden Andrew Booroff died of severe multiple injuries after being struck by a train on the tracks **[I/S]**

He had been admitted to the Linden Centre on 9th October '20 after experiencing a psychotic episode while staying with friends in Bristol.

At 19:56 on 23rd October, Jayden was able to abscond from the Linden Centre after tailgating a member of staff. Jayden ran from the building and travelled by foot towards Chelmsford town centre.

At 21:45, Jayden was struck by a train and killed.

There were a number of contributing factors that led to Jayden's absconsion, lack of capture, and subsequent death.

1. *Jayden had a history of illicit drug and alcohol use which contributed to his psychosis and led to intrusive thoughts, threats to self harm and a fear of being detained.*

2. *There was a family history of mental health which was not considered strongly enough.*

3. *There were a number of structural and environmental vulnerabilities that impacted staff and patient security and safety.*

4. *Inconsistencies with level of patient care, record keeping and communication.*

Jayden's use of illicit drugs and alcohol contributed heavily to his psychotic condition and if this had been addressed earlier, it may have made a difference to his health, well being and treatment.

More consideration should have been given to Jayden's relevant family history and more weight should have been given to this, alongside the diagnosis that his psychosis was triggered by drug and alcohol use only.

The layout of the Linden Centre, in particular the areas around the main doors, was not appropriate for ensuring the safety of its more vulnerable patients.

Procedures around the use and allocation of Pin Point alarms were inadequate.

The policy of recording and reporting absconsions from the Linden Centre was not clear enough, and led to a lack of awareness and a delay in addressing flaws in the system.

Responsibility for Jayden was not in line with policy and this contributed to a reduction in observation levels and inconsistencies in prescribed medications.

Communication between all healthcare professionals involved in Jayden's treatment was unsatisfactory, with mistakes being made in updating key documents. Risk assessments were not updated accurately enough or in good time, and failed to capture important information, including historical and emerging information.

Whilst there are lessons to be learnt following Jayden's absconsion from the Linden Centre, the response from Emergency Services and Network Rail were appropriate, and any alternative actions would not have altered the eventual outcome within the time that was available to them. "

320. I strongly believe that Jayden died due to the neglect of EPUT. The coroner however did not allow the jury to be left to consider the issue of whether neglect contributed to Jayden's death.

321. At the conclusion of Jayden's inquest, the coroner made a Prevention of Future Death ('PFD') Report in respect of EPUT and Essex Police. The PFD Report was also sent to me, BTP, and the CQC. The PFD Report raised four key concerns:

(1) Essex Partnership NHS Foundation Trust risk assessments missed key risk information that led to a reduction in observations levels on the ward.

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

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.

322. EPUT and Essex Police provided their responses to the PFD Report in March 2023.

Concerns with the Inquest process

323. I found the inquest process very traumatising, difficult and confusing. There were many incidents and decisions that left me feeling demoralised, betrayed, and let down all over again. The process was completely re-traumatising.

324. Some of the issues that I encountered during the inquest process included:

a. A last-minute pre-inquest review hearing was listed days before the final inquest hearing was due to begin, due to a last-minute issue raised by EPUT. This caused me significant stress and distress as I was preparing for a very difficult legal process and was avoidable.
b. Delayed disclosure by EPUT.
c. EPUT's approach appeared to me to be to blame Jayden as much as possible, for his illness and absconsion. This was reflected in their focus on Jayden's substance misuse.
d. An apparent failure by EPUT to demonstrate they had, in fact, learned lessons.
e. I found the approach of the coroner and her office lacked compassion and sensitivity. I was made to feel that Jayden's inquest was an inconvenience, and a statistic to process. It left me feeling completely demoralised, and that there was yet one more person and institution to fight against to try to get justice for Jayden, and to protect his legacy.
f. The inquest process felt adversarial; it did not feel like an investigation, and more of a process for parties to defend themselves and seek to shift the blame. There were three state organisations participating in this inquest which, in itself, felt very intimidating. I was left with the distinct impression that EPUT was there to seek to discredit Jayden; to build up a narrative that he was a violent and aggressive 'druggie', who was responsible for his death and that EPUT did the best they could. It also felt like Essex Police and EPUT were battling it out with each other, trying to shift the blame back and forth.
g. I found EPUT's approach to the inquest to lack any empathy. Their focus seemed to be on protecting their reputation, rather than preventing future deaths or trying to learn from any mistakes or missed opportunities.
h. I was also left with the impression, particularly from EPUT, that this was just one of many inquests that they go through.
i. EPUT's response to the PSII Report felt performative. EPUT provided evidence of changes made in response to the report at the inquest, which seemed to be motivated by the aim of avoiding the Coroner issuing a PFD report. I did not feel that they were genuinely seeking to improve patient safety. I note for instance that Jayden's absconsion was the 46th absconsion from the Linden Centre from November 2019 to October 2020[1]. If EPUT took absconsions seriously, it is not clear to my why it required my son to die before they made the relatively obvious decision to install airlock doors in a unit caring for detained inpatients.

325. Throughout the inquest process I was in a very heightened state of anxiety, anticipating having to defend Jayden's character and legacy.

[1] Core Service - Acute wards for adults of working age and psychiatric intensive care units - (29/11/2022) INS2-9774358681

334. I remember feeling hopeful that, with all the heat on EPUT at the time, from the Dispatches documentary, the media coverage, and the calls for a statutory inquiry, that they might finally start to take meaningful action and real steps to protect patient safety. However, during the inquest, I repeatedly heard empty reassurances of lessons learned, over and over, to the point that it lost all meaning. I was left feeling that EPUT just know they can do whatever, because they know there are no real consequences or enforceable actions from the inquest process. This came out really clearly in the process. It felt like, to them, it is just another inquest that they have to participate in.

335. In summary, I found the inquest process deeply traumatic. I had already been battling with the trauma of Jayden becoming unwell, and the trauma of him dying. The inquest process made these traumas considerably more difficult to process. The inquest process is a very cold process. It is brutal and harsh. It is a process that no mother should have to go through. For me, this was meant to be an opportunity to learn what really happened to my son, to see accountability be taken, and to walk away feeling reassured that, at the very least, no other family would have to suffer as I had suffered. For EPUT, this was another day, ticking a box, and focusing on reputation management. I was made to feel that this process was just an inconvenience: to the Coroner, in how much time it was taking up from her busy court schedule, and to EPUT, in having to participate and talk about my son.

336. I was not supported by EPUT throughout the inquest process, despite being open to their secondary mental health team. There seemed to be no acknowledgment from EPUT that going through the inquest process might be triggering and distressing, and that I would need increased support.

337. I am very concerned by the difficulties in the availability of legal aid funding for families in inquests, and the lack of knowledge generally that a family is given about their ability to obtain legal representation in an inquest. I could not have gone through this process without legal representation. No bereaved family should have to endure such a gruelling process without legal representation.

Civil Proceedings

338. I settled a civil claim against EPUT following Jayden's inquest. The tone in their letters exchanged with my solicitors continued to be defensive, and I felt no sense of justice or accountability in reaching this settlement. I think this was largely contributed to by knowing that deaths were still occurring under EPUT, at the time of reaching this settlement. It is hard to feel any reassurance that lessons have been learned, when you are aware of inquests ongoing at the same time, that are raising the exact same issues you came up against. Paul Scott did offer to meet with me and to apologise, as part of our settlement agreement. I have not yet taken him

up on that, as I do not believe it will bring me anything but hurt and disappointment.

Key Concerns

339. I would like to set out here some of the key concerns or issues that I observed throughout my contact with EPUT in relation to Jayden's care. These include:

a. **Poor communication with families:** I, like so many other families, was not informed of crucial updates and information concerning Jayden's care on both wards, nor was my view ever pro-actively sought. I had to fight, repeatedly, to be heard and raise my concerns with ward staff, and even then, I was ignored.
b. **Unsafe staffing**: I felt that there was an over-reliance on agency, bank or temporary staff who were not properly vetted or inducted, leaving them unfamiliar with patients. I also observed that permanent staff frequently moved between wards, creating no continuity of care for patients.
c. **Lack of training and qualification**s: Many staff, with seemingly very important responsibilities such as observations, were healthcare assistants with minimal training, inadequate skills, and no qualifications to care for acutely unwell psychiatric patients.
d. **Poor communication and record-keeping**: Records were incomplete or out of date. There is so much information about Jayden's care that I do not know because his records are incomplete, non-existent, or inaccurate. I worry about his records having been tampered with following his death. I have no trust in EPUT and so cannot rely on their records for any accuracy. So many of Jayden's care plans and risk histories were left unfinished. Staff failed to update one another on patient risks, vulnerabilities, or safety concerns. I, like so many other families, was left out of crucial information sharing, even when I was the one to have raised urgent concerns.
e. **Ward culture**: Both wards appeared to be chaotic, disorganised environments where staff often did not even know who their patients or colleagues were. Some staff mocked or played mind games with patients instead of showing empathy and compassion.
f. **Safety failures**: Security features were dangerously lax: Jayden was able to tailgate through three locked doors because staff did not check behind them and the ward was not equipped with the appropriate security and environmental safeguards to minimise the risk of patients absconding.
g. **Medication over care**: Psychiatrists over-prescribed powerful drugs as a substitute for therapy or meaningful treatment. Side effects were rarely monitored.
h. **Legal and procedural confusion**: As outlined in the PFD Report, staff, particularly at the Linden Centre, were unclear about who was detained under Section, who had Section 17 leave, and who could leave the ward unaccompanied. Patients who were detained for their own safety were mixed in with voluntary patients. Acutely unwell

patients suffering from psychosis were housed alongside more stable, lucid patients, creating unsafe, and frightening, environments for all patients.

i. **Lack of accountability**: Fatal staff errors were never met with dismissal or even serious sanction, as far as I am aware. I worry that some staff may have been promoted despite being responsible for preventable deaths. This is something I would like the Inquiry to look into. Senior management appeared to me to prioritise damage control and reputation over patient safety.

j. **Adversarial legal tactics**: At Jayden's inquest, EPUT's legal team attacked Jayden's character, and dehumanised him, rather than addressing systemic and individual failures. I, like so many other families, was retraumatised by a culture of denial and deflection.

Why This Cannot Continue

340. I strongly believe that if these behaviours and failures, as I have identified in my statement, and as have been identified in other families' statements, were happening in any other care setting, the response would have been immediate and severe. For example, in childcare settings: when abuse happens in nurseries, they are shut down immediately, and staff face prosecution, such as Little Ted's nursery in Plymouth which was permanently closed following alleged staff abuse. In other cases, nursery workers have faced lengthy prison sentences for cruelty and neglect. Yet when the same or worse neglect happens to psychiatric patients, who are just as vulnerable and in need of protection, there is rarely accountability. Even under the Animal Welfare Act 2006, neglect and cruelty can lead to prison sentences, unlimited fines, and lifetime bans on owning or working with animals. For example, in the Spindles Farm case, the owner received a prison sentence, a £400,000 fine, and a life ban for neglecting horses. I believe that vulnerable patients within EPUT have been treated with less care than children or even animals. All life is sacred. I do not understand why mental health patients are continually treated as 'lesser than'. Staff know they can act with cruelty or complacency without consequence, as they are shielded by legal teams and systemic indifference. This double standard is inhumane and must end.

341. Knowing what I know now about EPUT, it is clear to me that as soon as Jayden went into the Linden Centre, he lost all hope. He did not stand a chance, and he was always going to be failed. Those working within the system, up to the highest level, knew it was flawed and unsafe, and yet they continued on anyway. They continue on to this day.

Recommendations for change

342. I very much hope that the Chair is able to identify meaningful recommendations for change, to actually prevent further deaths in Essex mental health services. Some recommendations that I believe could begin to make a difference to this, include:

a. **Independent reporting and accountability:** To create a fully independent body where clinical staff can anonymously report corruption, abuse, or unsafe practices. If multiple reports are received about the same staff member, they should face immediate investigation, dismissal if substantiated, and possible legal action. Consequences should mirror other sectors, such as bans from working in healthcare after serious misconduct, just as bans exist in animal welfare or childcare.
b. **Safe staffing:** There needs to be an urgent and meaningful reduction in the over-reliance on agency staff. Mandatory vetting, by EPUT, and induction for all new staff should be introduced. Wards must ensure consistency of staff so patients are cared for by people who know them.
c. **Training and qualifications:** To set minimum qualification standards for frontline mental health staff. Mandatory training in trauma-informed care, risk assessment, and de-escalation should be implemented.
d. **Clear legal training:** All staff must be trained and regularly updated on diagnostic criteria, the Mental Health Act, Section status, and Section 17 leave rules. It should never be the case that staff are unsure who is detained or who can leave the ward.
e. **Ward separation and zoning:** Patients detained under section must be placed on separate wards from voluntary patients. Within wards, there should be clear separation between acutely unwell patients (e.g. psychosis) and more stable patients. This allows for targeted monitoring of higher-risk patients and creates safer environments for all.
f. **Communication and transparency:** Accurate, up-to-date patient records must be kept at all times. Families should be treated as partners in care and kept informed of key developments. Concerns raised by families must be listened to, recorded, and acted upon.
g. **Ward safety:** Security protocols must be enforced to prevent tailgating, to ensure the proper use of secure doors, and to incorporate regular safety drills to avoid staff becoming complacent and desensitised to the importance of keeping the ward safe. There should be zero tolerance for violence, sexual assault, or cruelty among staff or patients. This should go without saying, however as evidenced by what happened to poor Jayden and many others, these basic safety features are not always in place and a meaningful, cultural shift is urgently needed.
h. **Therapeutic focus:** Investment in and implementation of therapies, activities, and holistic care on the ward is needed, not just reliance on medication. Side effects of psychiatric drugs must be closely monitored.
i. **Accountability and leadership:** Staff responsible for fatal failings must face real consequences. Senior leaders should not be rewarded or promoted when systemic failings persist. Leadership must prioritise patient safety and dignity over reputation management.

j. **Legal and cultural reform:** At inquests and internal reviews, families should not be retraumatised by adversarial legal tactics. The focus must be on truth, accountability, and prevention of further deaths.

343. EPUT have repeatedly reassured families, coroners at inquests, the public, and even the Chair in this Inquiry, that many of the recommendations I have set out above are already in place or going to be put in place. However, it is clear that EPUT's current training, systems and culture are not fit for purpose and continued to put lives of the most vulnerable patients at risk.

344. Additionally, I think it is very important that the Inquiry incorporates within its thematic framework the investigation of *individual members of staff* whose repeated neglectful actions or failures have resulted in patient deaths, rather than referring solely to generic systemic issues.

345. This is essential to highlight how certain staff have been able to repeat the same failings due to a lack of individual accountability in the past. Without addressing this, those same individuals, many of whom remain employed within mental health services, continue to pose risks to vulnerable patients. Despite new policies and training initiatives, these measures have proven ineffective in preventing poor practice among specific individuals who consistently disregard professional standards. Holding such staff personally accountable would not only protect future patients but also serve as a meaningful lesson to others working within the system, demonstrating that poor practice, incompetence, and desensitisation, leading to the death of vulnerable people will no longer be overlooked or excused under the banner of "systemic failure."

Conclusion

346. Jayden's death was preventable. He was failed by a system that allowed complacency, cruelty, and confusion to thrive without accountability. If the same lack of care had happened to a child in a childcare setting, staff would have faced immediate investigation and sanction. Yet because he was a psychiatric patient, his life was treated as less valuable, and those responsible were protected. This must change. Vulnerable patients deserve the same protection, dignity, and compassion as any other human being.

347. I was there for Jayden's first words, his first steps, his first everything. It breaks my heart that I was not there for his last words, thoughts, steps, and moments. Jayden was brought into this world, placed into my arms, with love and care. He left this world cold, alone and afraid. I truly believe he did not want to die that night. He was robbed of a full and happy life.

348. Care has to be more than just medication or monitoring. For care to be effective it must be truly compassionate. Without systemic reform and accountability, more lives will be lost. My son's death must not be in vain.

Statement of truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court 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 in its truth.

Name: Michelle Booroff

Signed: .... [I/S]

Dated: 14 January 2026