REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], CEO, Essex Partnership NHS Foundation Trust** **2. Chief Constable of Essex Police**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 17 November 2020 an investigation into the death of Jayden Andrew BOOROFF, aged 23 years. Jayden Andrew Booroff died on the 23 October 2020. The investigation concluded at the end of the 10-day inquest on 25 November 2022. The conclusion of the inquest was narrative, *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, wellbeing 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 Pinpoint alarms was inadequate. The Policy recording and reporting absconsions from The Linden Centre was not clear enough and led to a lack of awareness and a delay in addressing the 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 the emergency services and [railway] were appropriate, and any alternative actions would not have altered the eventual outcome within the time that was available to them.* with a medical cause of death of '1a Severe Multiple Injuries due to a train collision.

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CIRCUMSTANCES OF THE DEATH

Jayden Andrew Booroff died of Severe Multiple Injuries after being struck by a train on the tracks adjacent to Widford Road, Chelmsford. He had been admitted to The Linden Centre on 19th October 2020 after experiencing a psychotic episode whilst 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 fear of being detained.*
2. *There was a family history of mental history 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.*

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CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 27st March 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • [redacted] *(Mother of Jayden)* and Simpson Millar Solicitors • British Transport Police and Weightmans Solicitors • Care Quality Commission I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
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	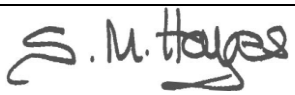 **27.01.2023** **HM Area Coroner for Essex Sonia Hayes**