



Department
of Health &
Social Care

*From Baroness Merron
Parliamentary Under-Secretary of State for
Women's Health and Mental Health*

*39 Victoria Street
London
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Our ref: PFD 26-02-06 – ZAMAN

HM Coroner Graeme Irvine
East London Coroner's Court, Queens Road, Walthamstow,
London E17 8QP
020 8496 5000

Coroners@walthamforest.gov.uk

25 March 2026

Dear Mr Irvine,

Thank you for the Regulation 28 report of 6 February 2026 sent to the Secretary of State for the Department of Health and Social Care about the death of Mansoor Dawud Zaman. I am replying as the Parliamentary Under-Secretary of State for Women's Health and Mental Health.

I would first like to express how saddened I was to read of the circumstances of Mr Zaman's death and wish to extend my condolences to his family. The circumstances your report describes are concerning and I am grateful to you for bringing these concerning matters to my attention in your Report.

The report raises concerns over the following:

1. The failure of nurses on the ward to instigate an authorisation under S.5(4) MHA 1983 when Mr Zaman returned to the ward after absconding on the afternoon of 8th December 2024.
2. The failure of nursing staff on the ward to adequately document observations and care decisions.
3. The failure of Trust staff to reappraise the level of risk presented by Mr Zaman to himself and others in light of his erratic behaviour on 8th December 2024, specifically,
 - a. His escape from the ward by violently kicking the fire exit door.
 - b. His aggression toward the duty doctor during assessment.
 - c. His assault upon a member of ward staff.
4. His second escape from the ward in identical circumstances to the first. The failure of Trust staff to re-assess the frequency and quality of observations that Mr Zaman should be subject to during the afternoon of 8th December 2024.
5. The failure of the duty doctor to act decisively and impose an authorisation under S.5 (2) MHA 1983 having been presented with an agitated patient who had minutes before escaped from the ward.

6. The dilatory response of staff on the ward to report Mr Zaman as a missing person to the police, an action that did not happen for almost three hours after it was known that he had absconded.
7. The categorisation of the risk presented by Mr Zaman as of a medium level by the nurse in charge when considering action to be taken after he absconded.
8. The use of the police 101 number as opposed to the required emergency 999 number to make the report.
9. The inadequacy of the Trust patient safety framework investigation which neither sought the recollections of treating staff, nor communicated the findings of the report to the same staff.

My officials have raised this case with the Care Quality Commission, responsible for the regulatory oversight of specified health, adult social care and mental health services, to seek assurances that the appropriate actions are being taken in response to this sad case. CQC have shared the following actions:

CQC attended a regular engagement meeting with East London Foundation Trust on 18 March. The trust updated CQC on their progress with investigating and learning from this specific incident. The trust recognised that the original PSII investigation report had not robustly covered one aspect of the incident and have commissioned a supplemental investigation and report relating to this incident. They are also reviewing governance processes to identify why this happened and reflect on learning in relation to this.

The original PSII report identified two areas for improvement, and the trust have already made changes. They have reviewed processes in relation to the administration of the MHA on the ward, with refresher information provided to staff. Environmental safety and security in relation to accessing and leaving the ward, with a focus on fire doors, have also been reviewed.

The supplemental investigation report and trust response to the coroner will be shared with CQC in early April. At this time the operational inspection team with support from the enforcement team expect to conclude their initial review of evidence in relation to this specific incident to inform a decision about whether further investigation work is needed.

CQC carried out a comprehensive inspection of acute and PICU wards at the Trust in late 2025, and are currently drafting the findings. CQC will continue to follow up on this incident through regular engagement with the Trust, looking at lessons learned and how these have been implemented and shared. They will also examine whether there are any emerging risks in relation to this incident and these can be followed up in a well led assessment planned for later in the year.

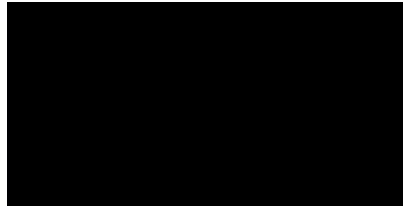
CQC Mental Health Act review colleagues will use the information relating to the use of Section 5(2) powers as intelligence during their ongoing programme of MHA review visits.

More widely, the changes we are making as part of the 10 Year Health Plan will improve quality and safety by making it clear where responsibility and accountability sits at all levels of the system. NHS England's mental health, learning disability and autism inpatient quality transformation programme will support cultural change and a new model of care for the future across all NHS-funded mental health inpatient settings.

I hope the information provided has been of help. I am copying this response to Jim Mackay, CEO of NHS England, and look forward to the response from the East London Foundation NHS Trust (ELFT) Trust, whom I hope will thoroughly address the matters of concern set out in your Report.

Thank you for bringing these concerns to my attention.

Yours sincerely,



BARONESS MERRON