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Private & Confidential

For the attention of HMC Graeme Irvine
East London Coroners Court
124 Queens Road Walthamstow, E17 8QP
Email: coroners@walthamforest.gov.uk

06 April 2026

Dear Sir,

RE: RESPONSE TO REGULATION 28

1. I write to provide the Trust's response to the concerns that you raised at the conclusion of the inquest touching the death of Mr Mansoor Zaman as set out below:

Concern 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.

Concern 2 –The failure of nursing staff on the ward to adequately document observations and care decision.

Concern 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

Concern 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.

Concern 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.

Concern 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.

Concern 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.

Concern 8 – The use of the police 101 number as opposed to the required emergency 999 number to make the report.

Concern 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.

2. I gratefully note your observations and seek to assure HM Coroner and the family of Mr Zaman that the Trust has undertaken a great deal of reflection and learning since Mr Zaman's very sad death on 29 December 2024.

3. I asked the Trust's Risk and Governance Team to complete an addendum to the Patient Safety Investigation (the 'Addendum') into Mr Zamon's death. The purpose was to provide additional context and clarification on aspects of care that were not explored in the Trust's PSII as well as to support Newham Centre for Mental Health (NCfMH) to put into place robust and meaningful actions to address these concerns and prevent future deaths.

4. I understand the Addendum has been disclosed with this response and provided to the family of Mr Zamon.

5. Please find our response to each concern under the themes: Risk Assessment, Observations, Holding Powers, AWOL response, Record Keeping and Patient Safety Investigation response.

RISK ASSESSMENT

- **Concern 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

- **Concern 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.**

6. The Addendum highlights that identifying risk in service-users requires clinical staff to consider a combination of structured assessment, ongoing observation, and dynamic clinical judgement in real time. Relevant factors included in this process are the service user's history of violence, self-harm, suicide attempts, and previous AWOL episodes.

7. It is not clear that this was done consistently and in real time on the day Mr Zamon left Ruby Triage Ward (the 'Ward'). There was a significant delay in updating the RiO Adult

   Risk Assessment after Mr Zamon's first unauthorised absence. It also did not identify that he was high risk. The telephone call to the duty/resident doctor to attend Ruby Triage Ward (the 'Ward') indicates that there was an appreciation by staff that Mr Zaman's risk was increasing. However, when the duty resident doctor stopped the clerking process due to Mr Zaman's increasing aggression to discuss the use of Section 5(2) with the senior on-call doctor, then Mr Zamon assaulted a member of ward staff and left the ward for a second time, it is not clear that ward staff appreciated Mr Zaman's increased risk. Whilst actions were undertaken, they did not reflect the appropriate level of risk.

8. It does appear that the senior nurse did not appreciate that Mr Zaman's risk was high until the police were called three hours later and that level of risk was considered by her to be due to the amount of time that had passed since he absconded from the Ward, not his presentation during the incident.

9. I discuss the actions the Trust is taking to improve the quality of its risk assessment amongst staff in the section on observations below as the two issues are inter-linked.

OBSERVATIONS:

- **Concern 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.**

10. The Addendum also notes that Mr Zaman's observation levels were not increased to reflect the heightened risk following his first unauthorised exit. Continuous 1:1 eyesight observation should have been considered at that time. Additionally, zonal observations on the fire exit would have been appropriate and would have illustrated an appreciation of increasing risk. It appears that zonal observations were considered, though they were not implemented because of the rapidly changing clinical situation.

11. To improve staff risk assessment and observation practice the Ward staff will undertake mandatory refresher training on completing structured risk assessments and documenting dynamic changes in risk. This includes practical guidance on when observations should be increased and when zonal observations should be used. It will also highlight clear expectations for recording changes in presentation in real time. This will take place within the next two months.

12. Compliance with training will be monitored by monthly audits of 10 randomly selected risk

assessments. Audits have an expected compliance rate of at least 90% for documentation of key risk factors and dynamic risks.

13. Further, MDT communication will be strengthened by the continued implementation of the Relational Security Initiative at NCfMH (the 'Initiative'). Relational security refers to clinicians' knowledge and understanding of service users and their environment, and the translation of that information into meaningful care. Since August 2024, several phases of the Initiative have been completed including training facilitators, unit-wide events and on-ward 'bite-size' sessions with staff teams. At the next session, the application of Relational Security to this incident will be considered. It is anticipated the training will aid clear team--based discussion, documentation, and shared decision-making whenever a patient's risk level changes or escalation is being considered

HOLDING POWERS

- **Concern 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.**

- **Concern 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.**

14. I have discussed HM Coroner's concerns surrounding the use of section 5(4) and s.5(2) holding powers with the Trust's Associate Director of Mental Health Law and the Trust's external solicitors. In relation to **Concern 1** it is helpful to set out section 5(4) of the Mental Health Act 1983 (MHA).

   "*If, in the case of a patient who is receiving treatment for mental disorder as an in-patient in a hospital, it appears to a nurse of the prescribed class—*

   (a) *that the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital; and*

   (b) *that it is not practicable to secure the immediate attendance of a practitioner or clinician for the purpose of furnishing a report under subsection (2) above*"

15. Section 5(4) is clear that the power should only be invoked if the immediate attendance of a doctor may not be secured. It is the Trust's expectation that a nurse should be able to secure the immediate attendance of a doctor or approved clinician. During the day, regular medical staff will generally be present on the ward. At night or "out of hours" there is a medical staff member on duty for this purpose.

16. It is possible that a situation may arise where immediate attendance is not possible. An example of this would be where the 'out of hours' duty doctor is attending to an emergency on another ward. In that case it is appropriate for the nurse to invoke section 5(4) for up to six hours after they first carry out an assessment in line with paragraph 18.29 of the MHA Code of Practice.

17. In the present case, the immediate attendance of a doctor was secured. Therefore, section 5(4) powers were not lawfully available for the nurse to invoke.

18. In relation to **Concern 5**, I set out section 5(2) of the MHA.

    'If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner or approved clinician in charge of the treatment of the patient that an application ought to be made under this Part of this Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished.'

19. The MHA Code of Practice is also relevant and it further states at paragraph 18.4, set out below:.

    '*Doctors should not be nominated as a deputy unless they are competent to perform the role. If nominated deputies are not approved clinicians (or doctors approved under section 12 of the Act), they should wherever possible seek advice from the person for whom they are deputising, or from someone else who is an approved clinician or section 12 approved doctor, before using section 5(2). Hospital managers should see that arrangements are in place to allow nominated deputies to do this.*'

20. The Mental Health Act Manual 28th Edition, by Richard Jones further states,

    '*the nominated clinician, who could be a junior doctor, should exercise her own judgement when exercising the power under s5(2). She can be advised but not required to consult with a senior colleague before exercising the power.'*

21. The junior doctor in this case was the nominated deputy. They are not an approved clinician nor approved under Section 12 of the Act. They promptly sought the advice of a more senior doctor, who was section 12 approved. This was the arrangement in place on 8 December 2024 for nominated deputies. They were not required to consult the senior doctor. However, it is the Trust view that it was good practice (and in line with the MHA Code of Practice) for them to do so considering the situation was high risk but did not yet present with an immediate life-threatening emergency.

22. It is important to note, that neither Section 5(2) or 5(4) provide the same powers to clinicians as section 2 or 3 of the MHA. It is only a holding power and does not allow for treatment (including rapid tranquilisation). Under section 5(2) or 5 (4) rapid tranquilisation would require consent of the patient as per section 4 (3)(b) of the MHA and paragraph 18.41 of the MHA Code of Practice. The latter states:

    "*Detaining patients under section 5 does not confer any power under the Act to treat them without their consent. The rules in part 4 of the Act do not apply to these patients. In other words, they are in exactly the same position as patients who are not detained under the Act in respect of consent to treatment.*"

23. The Trust is of the view that rapid tranquilisation is generally not an appropriate method for enforcing detention. In rapidly escalating emergency situations, the Mental Capacity Act 2005 or possibly the common law may be available to clinicians to support the use of rapid tranquilisation. It may not be appropriate to wait for holding powers in those situations. However, without further detailed exploration of those options, it is unclear to me if they would have been appropriate in this instance.

24. That said, I was appraised of the oral evidence heard at inquest. The explanations provided by some (but not all) of the staff as to how section 5(4) or 5(2) are used were not in-line with the legal requirements set out in the MHA. This is a matter of concern to the Trust. Consequently, at the time of inquest, I requested that the ward staff undergo refresher training in relation to their holding powers. This took place on 25 February 2026. Within the next 6 months, the Associate Director of Mental Health Law is going to hold a further refresher session with the all the ward staff to include situations when the MCA may be used in an emergency. They will also update the rapid tranquilisation policy to ensure it restates this position with clarity.

AWOL RESPONSE

- **Concern 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.**

- **Concern 8 – The use of the police 101 number as opposed to the required emergency 999 number to make the report.**

25. The Addendum sets out that the Trust's AWOL Policy in place at the time of the incident, requires the nurse in charge to take immediate action. Accordingly, the Duty Senior Nurse and the junior doctor was notified that Mr Zaman absconded. The on-call doctor asked the nurse in charge to contact the police and to inform medical staff if he returned. This was repeated to the ward staff after the junior doctor spoke to the senior doctor again and confirmed that the police should be called.

26. The nurse in charge proceeded on the basis that further local actions were appropriate before police escalation. This was in line with the AWOL policy, including initiating a search of the ward and surrounding external areas and making several calls to the nearest relative. The incident was reported to police around 3 hours after Mr Zaman left the ward for the second time.

27. It appears the nurse in charge was still working on the basis that Mr Zaman was medium risk. This explains why the police were called via 101. Under the AWOL policy, 101 would normally be used for a medium-risk absence, while 999 would be expected where the patient is considered high risk. However, with time, Mr A was described as high risk when the 101 call was made.

28. I agree that Mr Zaman was a high risk, missing person. His absence should have been reported via 999, and an AWOL Grab Pack should also have been completed to support the police response in line with the London AWOL and Missing Persons Policy and the Pan-London Joint AWOL Policy,

29. You heard at the inquest that the Trust's AWOL policy has been refined and makes it clear when 999 should be called. Additionally, within the next two months, the ward staff will undergo refresher training on both policies and understand how they apply together in practice, so that AWOL procedures are followed consistently and safely.

30. The senior clinical team will also develop and implement mandatory AWOL policy training for all clinical staff, including a competency assessment covering both the Trust AWOL Policy and the Pan-London Joint AWOL Policy.

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DOCUMENTATION AND COMMUNICATION

- **Concern 2 –The failure of nursing staff on the ward to adequately document observations and care decision.**

31. The addendum makes it clear that information on risk, observations and care decisions were not consistently documented. This included telephone calls made to the nearest relative, the one-to-one discussions with the nurse in charge, and the absence of a dedicated LFPSE report for the second absconsion.

32. The Relational Security Initiative outlined under the Observations section above will reinforce the importance of accurate and timely documentation.

PATIENT SAFETY INVESTIGATION RESPONSE

- **Concern 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.**

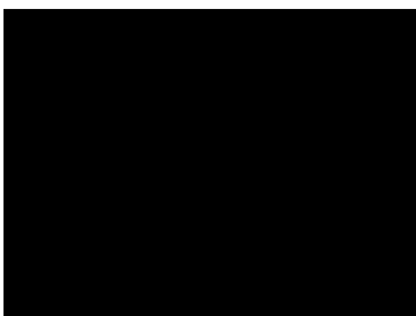
33. I understand it is frustrating that recollections of all staff are not always sought in PSIIs nor the findings communicated to all staff. Unfortunately, it is sometimes a balance of trying to obtain all clinician accounts (due to things such as sick leave) versus timely completion of the investigation. The same applies to feedback sessions. Though, to mitigate these issues, when staff are unable to attend feedback sessions they are routinely provided with a copy of the final report via email and asked to comment on it.

34. The Risk and Governance team has been apprised of your concerns and asked to keep it in mind to ensure when these situations arise they are achieving the correct balance.

Conclusion

35. I hope this response provides sufficient reassurances to you and to the family of Mr Zaman about the learning that has taken place at the Trust since his sad death.

36. I would like to offer my sincere and heart-felt condolences to his family at this difficult time.



Chief Medical Officer