Patient Safety Incident Investigation (PSII)

Addendum to Final Report

Incident ID number:	[redacted]
Date incident occurred:	30th December 2024
Incident type	Death of an Adult Service User
Directorate	Newham Centre for Mental Health
Service	Ruby Triage Ward
Report Author	[redacted]
Report approved date:	1st April 2026
Approved by:	[redacted] Director of Nursing, Mental Health, London
Reason for Addendum:	To support the response to the Prevention of Future Deaths (PFD) Regulation 28 report and address the coroner's concerns regarding risks and delays in notifying the police.
Report Version: I	Final
Date of Addendum:	1st April 2026

Contents:

1. Purpose of this addendum

This addendum provides additional context and clarification on aspects of care that were not explored in detail in the main report. It focuses on post-admission care, including the management of events following the first unauthorised exit from the ward, the second unauthorised exit, and the escalation process that followed.

2. Ward clinical context

Weekend staffing was reviewed and considered appropriate for ward activity, with two Band 5 RMNs and four Band 3 social therapists on shift. One of the RMNs was acting as nurse in charge and shift coordinator. Weekend MDT presence was reduced, with a single on-call doctor covering the unit and responsible for new admission clerking.

Four patients on physical health observations; this required enhanced monitoring of their vital observations. Two of these patients required twice daily checks, 1 was 4 times daily and 1 was once a day. There were 3 sets of mental health intermittent observations including Mr. A. This required checks to be completed every 15 minutes of their whereabouts and general safety. Enhanced care was provided to four patients requiring physical health observations and three patients on intermittent (15-minute checks) mental health observations, including Mr A. At 13:30, the Emergency Nursing Team (ENT) attended the ward to support restraint and depot administration for another patient.

AWOL Policy instructs staff to confirm a person's absence, search in and around the unit and inspect CCTV.

3. Admission and initial risk assessment

The Clinical Risk Assessment and Management Policy requires risk assessments to focus on a person's needs and support their immediate and longer-term psychological and physical safety. Information may be gathered through patient interview, record review, collateral information, and engagement with the patient. Expected practice is that a risk assessment is completed at inpatient admission and documented on the RiO Adult Risk Assessment Form. For patients already known to services, Dialog+ should be updated within 72 hours of admission.

Following admission at 10:05, Mr A was orientated to the ward environment. He then went to his bedroom and was asleep by 10:53. As he was asleep, staff were unable to complete the risk assessment collaboratively at that time. In line with expected practice, staff did not wake him and instead planned to continue and refine the assessment once he was awake and able to engage. As Mr A remained asleep from 10:53 to 14:30, it was reasonable that admission assessments and clerking were only partially completed during this period. The ward staff followed policy.

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assessments and clerking were only partially completed during this period. The ward staff followed policy.

Mr A's initial risk assessment review was initiated at 11:53. Risks to self and others were documented, including a known history of aggression when his needs were not met immediately. At the time of admission, however, he had not displayed any aggressive behaviour on the ward and was asleep. This would have been updated once Mr A had been seen and clerked by the doctor after he awoke.

The risk of self-harm reflected the circumstances of the current admission, specifically that Mr A had been found near Southwark Bridge with reported intentions to enter the water. Risks of escape and absconsion were also recorded, as it had been reported that he had attempted to leave the Section 136 place of safety. This information was appropriately documented to inform ongoing assessment and observation. Overall, the approach was clinically appropriate and consistent with standard practice, balancing the need for ongoing risk assessment with respect for Mr A's immediate presentation and wellbeing.

Intermittent 15-minute observations were prescribed when Mr A arrived on Ruby ward at 10:05, and records show these were completed with no missed recordings.

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4. First unauthorised exit from Ruby ward

At 14:26, Mr A left his room and approached the nursing office to speak with staff. He requested to leave the ward to smoke. At this point, staff had ongoing concerns about his presentation, given the circumstances of his admission and the fact that medical clerking had not yet been completed.

In line with expected practice, staff explained that he could not leave the ward until he had been reviewed by a doctor as part of the admission process. This decision was proportionate to the risks identified at that time and consistent with standard inpatient admission procedures.

At 14:33:56, Mr A exited the ward through the fire door, which is not visible from the nursing office. His departure was unwitnessed, as staff were carrying out routine observations and had no indication that he had left the ward.

At 14:35, staff completing routine observations were unable to locate Mr A. Once it was established that he was absent from the ward, staff acted promptly by initiating a full ward search, including bedrooms, communal areas, and accessible ward spaces. Mr A could not be located. A member of staff went out in their car, located Mr A offsite, and returned him to the ward at 15:17:38. The ward staff followed the Trust's London Absent without Leave (AWOL) and Missing Persons Policy.

On return to the ward, Mr A was searched by two members of staff in line with the Trust's Searching Service Users and Property Policy. He cooperated with the search and voluntarily handed over cigarettes, which were retained for safekeeping. The search was proportionate, respectful, and limited to what was necessary to manage immediate safety risks following an unauthorised absence. An InPhase incident record (ID 24543) was completed for the first unauthorised absence at 16:44.

5. Actions following the first unauthorised exit

The AWOL Policy states that, on return to hospital, the patient must be reviewed by the nurse in charge as soon as possible. This post-return review should include mental and physical state, current level of risk, required level of observation, and any specific care needs. Information gathered should then be used to reassess future risk and inform any necessary changes to the care plan.

The review identified that the nurse in charge contacted the on-call doctor following Mr A's first unauthorised absence. Although staff were unable to recall the exact time the call was placed, there is corroborating evidence that the on-call doctor acknowledged the request and attended the ward at 15:20. This supports that escalation to medical staff occurred in a timely way following the incident.

The nurse in charge was aware of Section 5(4) of the Mental Health Act 1983, which allows a nurse to prevent an informal inpatient from leaving hospital where there is immediate concern about safety and no doctor with Section 5(2) authority is immediately available. In this case, Section 5(4) was not used because the on-call doctor had already been contacted and was immediately available to assess Mr A. Although this reasoning was not formally recorded, it was clinically understandable in the circumstances.

When the on-call doctor arrived, clerking commenced in a separate room. Mr A remained on intermittent 15-minute observations. During this time, he was visible to staff from a respectful distance. The nurse in charge explained that maintaining some distance was intended to avoid causing further distress while still allowing staff to observe him safely. Therapeutic observations and zonal observations were not reviewed at that stage, as the nurse understood there to be an active medical assessment underway.

6. Medical review and interrupted clerking

During the admission clerking, the doctor observed that Mr A appeared tense, emotionally withdrawn, agitated and aggressive. He repeatedly stated that he wanted *"nature to take its course."* The doctor interpreted this as an expression of emotional distress and potential risk, rather than a neutral statement.

In response, the on-call doctor made the clinical decision to stop the clerking at 15:25:12. This was done because Mr A was showing signs of distress and disengagement, and continuing the assessment was unlikely to be clinically useful and may have increased risk. The doctor was also concerned by Mr A's aggressive behaviour and considered that sedation might be required. The doctor then went to the nursing office to consult the second on-call doctor by telephone about possible use of Section 5(2). The nurse in charge did not recall being told that the clerking had been terminated, although she did witness the staff member being assaulted.

7. Second unauthorised exit from the ward

CCTV shows that at 15:31 Mr A became physically aggressive towards a staff member, prompting another staff member to intervene. The Duty Senior Nurse and Emergency Nursing Team were not contacted, and the situation was managed by the ward team.

Over the next few minutes, Mr A was seen pacing near the fire exit and moving between his bedroom and the corridor. At 15:37:06, while the on-call doctor was still in discussion in the nursing office, Mr A kicked the fire exit door and left the ward for a second time. The door closed behind him at 15:37:10. The sound of the fire exit door alerted staff, who responded immediately and attempted to locate Mr A in the surrounding area.

8. Actions and escalation following the second unauthorised exit

In accordance with the AWOL Policy, the nurse in charge was required to take immediate action. The Duty Senior Nurse was informed, and at 15:39:18 the on-call doctor was notified that Mr A had left the ward for a second time.

At 15:59, the on-call doctor documented concerns about Mr A's risk to others, noting that he had previously assaulted a staff member and had repeatedly reported suicidal thoughts. The on-call doctor asked the nurse in charge to contact the police and to inform medical staff if Mr A returned. The nurse in charge did not call the police at the time and it appears the nurse in charge proceeded on the basis that further local actions were appropriate before police escalation in line with policy. This included actions staff took once they confirmed Mr A's absence – they initiated a search of the ward and surrounding external areas. CCTV was not reviewed immediately because ward staff did not have direct access to it and access required matron support. Mr A was not contacted by phone because it was known that he had destroyed his phone while in the Health Based Place of Safety.

A RiO entry at 16:04 states that several calls were made to Mr A's nearest relative, his mother. The review found that contacting his mother was reasonable and proportionate at that stage. Although documentation could have been clearer, this appears to be more a record-keeping issue than a failure to act. A clearer record of the calls and any subsequent conversations with the family would have provided better evidence of information shared and actions taken to locate Mr A.

Medical escalation was already underway when Mr A left the ward for a second time, and events moved quickly, meaning there was limited opportunity to implement Section 5(2) before he left again. However, although risk was being reviewed and police contact had been advised, there is no clear evidence that this updated view of risk was explicitly communicated across the MDT at the time. This reflects the challenges of timely communication amongst the MDT when managing an immediate/emergency clinical situation, than to a failing by any one individual.

A RiO entry at 16:41 states that the risk assessment had been updated. However, the Adult Risk Assessment was not updated on RiO until 18:12.

At 17:54, the on-call doctor spoke to the more senior on-call doctor for a second time to update her that Mr A had left the ward again before Section 5(2) could be initiated. She also advised that nursing staff should inform the police and contact his family.

9. Risk documentation and recording

When the risk assessment was updated, it reflected staff actions, searches, and escalation to both medical staff and the Duty Senior Nurse. The review concluded that the risk assessment documentation was updated within a reasonable timeframe.

At 18:13, the nurse in charge completed an InPhase incident record (Non-LFPSE 10063) relating to the incident in which Mr A knocked off a staff member's glasses. This report also recorded that Mr A had kicked the fire door and left the ward for a second time.

The incident report stated that the risk assessment had been updated and that the police had been notified. However, this was not clearly recorded in Mr A's medical records on RiO.

10. Police notification

The incident was reported to the police at 18:35, around two hours and 58 minutes after Mr A left the ward for the second time. Although the ward was busy, this alone does not fully explain the timing. If Mr A had been clearly understood by the ward team to be high risk at the point of the second absence, police contact would likely have been prioritised earlier.

The evidence suggests that the nurse in charge was still working on the basis that Mr A was medium risk when he first arrived on the ward and left the ward. By the time she contacted police, her perception of risk had changed, in part because Mr A had then be off the ward longer than his previous absence, which is why Mr A was then reported to police as high risk. This suggests that the main issue was not simply workload, but that the changing level of risk and the need for escalation were not clearly shared in real time.

A RiO entry at 18:35 states that the incident was reported to the police via 101. Under policy, 101 would normally be used for a medium-risk absence, while 999 would be expected where the patient is considered high risk. However, Mr A was described as high risk when the 101 call was made.

11. Conclusion

The shift coordinator has reflected on the events of the day, the factors contributing to the identified omissions, and the lessons learned from the incident. This addendum reaffirms the concerns outlined in the PSII and highlights additional matters requiring attention.

11.1 Documentation

Key information was not consistently documented. This included telephone calls made to the nearest relative, the one-to-one discussion with the nurse in charge, and the absence of a dedicated LFPSE report for the second absconsion.

11.2 Risk assessment and observation

Risk was not clearly identified as high immediately following the first unauthorised absence, as reflected in the delay in updating the RiO Adult Risk Assessment, which was not amended until 18:12. Observation levels were also not increased to reflect the heightened risk following the first unauthorised exit. Although zonal observations for the fire exit were considered, they were not implemented because of the rapidly changing clinical situation.

11.3 Escalation

There was a delay of almost three hours in notifying police following the second unauthorised absence. As also identified in the PSII, the timing of police notification fell outside what would be expected for a clearly recognised high-risk patient missing from the ward. The addendum also identified uncertainty about the reporting process, with Mr A being described as high risk while reported via the 101 line. Staff were unfamiliar with the Pan-London Joint AWOL Policy, and the police Grab Pack was not completed.

The PAN London Policy which was introduced after the Right care Right Person. There is a dedicated section titled “Making the decision to inform the police.” It states that regardless of a person’s legal status, if they were at risk of serious harm, there absence should be reported to the police via 999. Staff should also complete a Required Information ("Grab Pack")

- Trusts must provide a standardised information pack that includes:
- Patient identifiers and photographs
- Risk factors
- Mental/physical health concerns
- Details of last sighting
- Search actions already completed
-

This was not considered at the time, and it was still felt that Mr A was not a missing person and would be around the grounds. The Nurse in Charge felt this was an oversight on her part.

The review recognises that the doctor instructed the nurse to contact the police on two separate occasions. However, there is no documented evidence of a coordinated MDT discussion or shared decision-making process that clearly established Mr A's level of risk at that time and what action was required under the AWOL policy. This suggests that escalation was not fully managed as a shared team responsibility but instead appears to have been left mainly to the nurse in charge to interpret and act on alone.

12. Further learning and recommendations

12.1 AWOL and missing person's process

The on-call doctor stopped the clerking process because of increasing concern about risk and to discuss possible use of Section 5(2) with the senior on-call doctor. During this period, Mr A left the ward for a second time. Although the on-call doctor recognised the risk and requested police notification, there was a delay before Mr A was reported missing. By the time police were contacted via 101, Mr A was reported as high risk because he had not been located and time had passed.

A high-risk missing person should have been reported via 999, and a Grab Pack should also have been completed to support the police response. This was not done. The London AWOL and Missing Persons Policy and the Pan-London Joint AWOL Policy were therefore not fully followed.

It is recommended that all Ruby Triage Ward staff are made fully familiar with both policies and understand how they apply together in practice, so that AWOL procedures are followed consistently and safely.

It would also be beneficial for the senior clinical team to 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.

12.2 Risk assessment and dynamic observation

Identifying risk in high-risk patients requires structured assessment, ongoing observation, and dynamic clinical judgement. Relevant factors include history of violence, self-harm, suicide attempts, and previous AWOL episodes.

Ruby Triage Ward staff would benefit from a mandatory refresher session on completing structured risk assessments and documenting dynamic changes in risk, including practical guidance on when observations should be increased and when zonal observations should be used. This should include clear expectations for recording changes in presentation in real time.

Compliance could be monitored through a monthly audit of 10 randomly selected risk assessments, with an expected compliance rate of at least 90% for documentation of key risk factors and dynamic risks.

Strengthen MDT communication and relational security by requiring clear team--based discussion, documentation, and shared decision-making whenever a patient's risk level changes or escalation is being considered.

Since August 2024, the teams in Newham Centre for Mental Health have been part of the Relational Security initiative in ELFT. Relational security is the knowledge and understanding we have of a service user and of the environment, and the translation of that information into meaningful responses and care. The roll-out in NCMH has involved a number of phases including training up facilitators, unit-wide events and on-ward 'bite-size' sessions with staff teams. These sessions encourage staff to discuss and reflect on relational security when applied to a number of key areas including boundaries, risk awareness, patient/staff mix, visitors, the personal world (i.e. what has happened to people and what is most important to them) of patients and staff.

12.3 Shift coordination and delegation

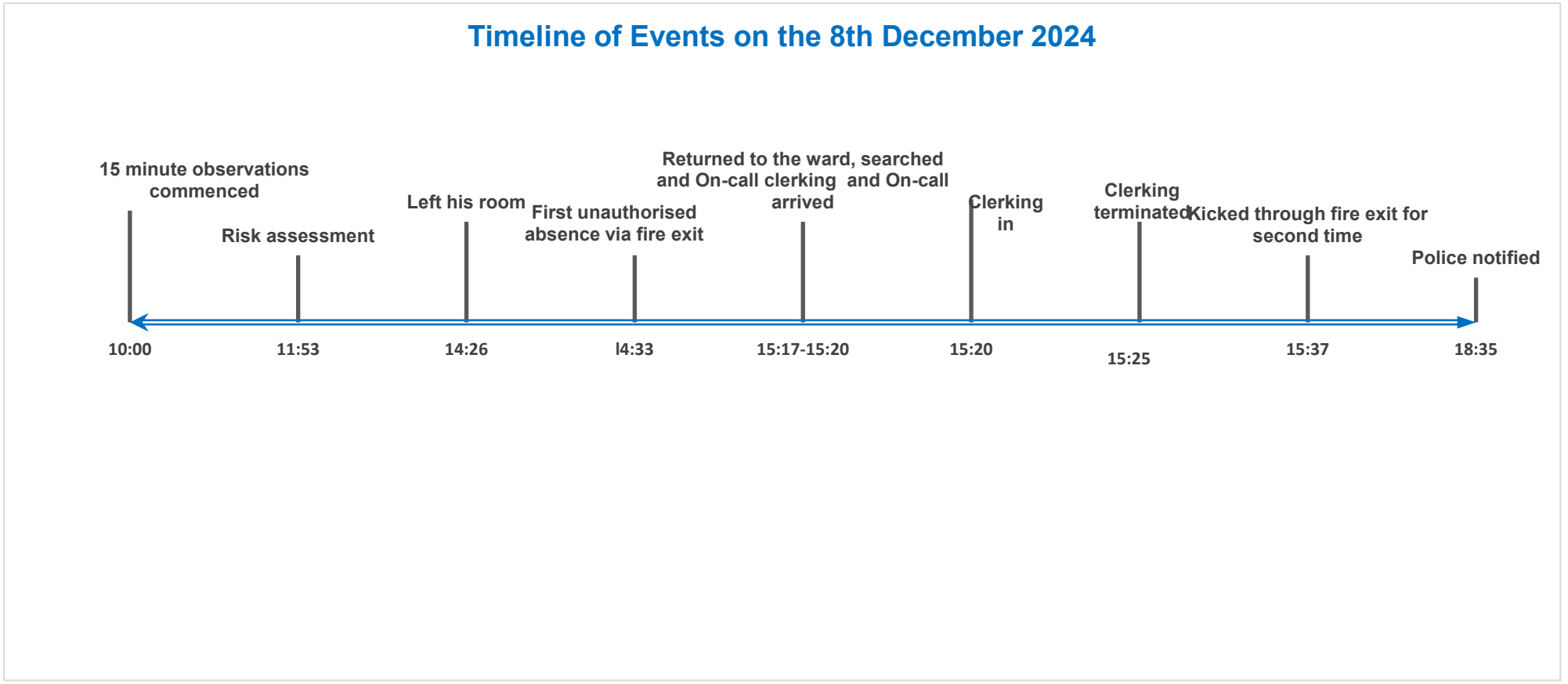
On the day of the incident, shift coordination did not function as effectively as it should have, resulting in some key duties being delayed or overlooked. Shift coordinators on Ruby Triage Ward would benefit from additional support and opportunities to build confidence in delegation, escalation, and risk identification. The Ward Matron has already implemented a support plan and mentoring for the nurse in charge who was on duty that day, and is also seeking wider confidence-building support for the broader ward team

Appendix 1. Chronological Timeline of Events on Sunday 8 December 2024

Time	Event / Description
10:00	Intermittent 15-minute observations were initiated. Mr A was orientated to the ward and then went to sleep. Staff could not complete the collaborative risk assessment because he was asleep. Staff planned to complete the assessment once he was able to engage.
11:53	Initial Adult Risk Assessment completed on RiO. Risks recorded included a recent incident at Southwark Bridge indicating self-harm risk, risk of escape/absconsion, and a known history of aggression when needs are not met, although no aggression was observed on admission. Assessment was judged proportionate.
14:26	Mr A left his room and approached the nursing office requesting to leave the ward to smoke. Staff explained he could not leave until after medical review due to the circumstances of admission, incomplete medical clerking, and immediate safety concerns.
14:33:56 First unauthorised absence	Mr A exited the ward via the fire door, unseen by staff.
14:35	Staff could not locate Mr A during observations. A full ward search was initiated, including bedrooms, communal spaces and accessible areas. Mr A was not found.
15:17:38	External search conducted. A staff member located Mr A offsite using a car and returned him to the ward.
Approx. 15:17–15:20	Mr A was searched by two staff in accordance with the Searching Policy. He cooperated and handed over cigarettes for safekeeping.
15:20	The on-call doctor attended following staff escalation. Nursing and medical staff jointly assessed Mr A, with a staff member present throughout for support and observation.
18:21	Risk assessment updated on RiO to include the first absence.
Post-first incident	Staff were aware of potential use of Section 5(4) but did not apply it because a doctor was already confirmed as attending. Escalation to the on-call doctor was considered appropriate and timely.
15:25:12 Clerking and emerging concerns	During clerking, Mr A appeared tense and withdrawn and repeatedly stated he wanted “nature to take its course.” The doctor interpreted this as emotional distress and possible risk. Clerking was ended early to avoid further escalation. The doctor consulted the second on-call doctor regarding the possible need for Section 5(2).
15:31	Mr. A was seen engaging with a staff member before he grabbed their glasses from their face and threw them to the ground
15:37:06 Second unauthorised absence	Mr A kicked the fire exit door.
15:37:10	The door closed behind him and he had left the ward. Staff were alerted by the noise and responded immediately.
15:37–15:39	Staff began immediate external searching in accordance with AWOL Policy.
15:39:18	The on-call doctor was notified that Mr A had absconded for a second time. Medical escalation was already in progress regarding possible Section 5(2).
15:59	The on-call doctor documented concerns including risk to others, a previous attack on staff, and recurrent suicidal thoughts. The doctor instructed nursing staff to contact police and notify the doctor when Mr A returned.

	Staff did not record any of the attempts that were made to contact the police
16:04	RiO entry recorded several attempts to contact Mr A's mother, but no outcomes or details were documented.
16:41	RiO entry stated that the risk assessment had been updated (actual update recorded at 18:12).
16:44	InPhase Incident ID 24543 completed for the first unauthorised absence.
17:54	On-call doctor documented discussion with the senior second on-call doctor. Advice given was to contact police, contact family, and allow the police to use professional judgment.
18:12	Adult Risk Assessment on RiO updated to include both unauthorised absences.
18:13	Nurse in charge completed Incident ID Non-LFPSE 10063, recording the aggression incident, the second absconsion, the risk assessment update, and police notification.
18:35	Staff contacted police via 101, approximately 2 hours and 58 minutes after Mr A's second absconsion. No separate LFPSE incident was created for the second absence. Review team noted that both incidents were reported on InPhase about two hours after each event occurred.

Appendix 2. Timeline of events



References

Clinical record keeping Policy 2.1

East London NHS Foundation Trust Therapeutic Engagement and Observation Policy 9.0

London Absent Without Leave (AWOL) & Missing Persons Policy 6.0

Pan-London Mental Health Trusts Joint AWOL Policy

East London NHS Foundation Trust Clinical and Risk Management Policy 5.2