MR G IRVINE
SENIOR CORONER
EAST LONDON CORONERS COURT
124 Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Interim Chief Executive Officer, The East London Foundation NHS Trust (ELFT)** [redacted] **2. [redacted], Secretary of State for Dept. Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 10th January 2025, this court commenced an investigation into the death of Mansoor Dawud Zaman aged 27 years. The investigation concluded at the end of the inquest on 30th January 2026. A jury returned a shortform conclusion of suicide along with a narrative that cited failure of staff on a mental health ward on 8th December 2024 as factors that probably contributed to death, these were:

	• The failure of the nurse in charge to authorise treatment under S.5(4) Mental Health Act 1983. • The failure of a reviewing doctor to authorise treatment under S.5(2) of the Mental Health Act 1983. The jury also determined that the following factors possibly contributed to the death: • The failure to increase the frequency of observations after Mr Zaman escaped the ward and then returned earlier on 8th December 2024. • The failure of staff on the ward to reappraise the level of risk presented by Mr Zaman on 8th December 2024. Mr Zaman's medical cause of death was determined as: 1a Immersion in water
4	**CIRCUMSTANCES OF THE DEATH** Mansoor Zaman was a 27-year-old man with a history suicidality, substance misuse and a diagnosis of Emotionally Unstable Personality Disorder ("EUPD"). Following a period of inpatient treatment at the Newham Centre for Mental Health ("NCMH") following a suicide attempt, Mr Zaman was discharged into the community. On the evening of 6th of December 2024 The City of London Police attended to Mr Zaman, sitting on the side of Southwark bridge over the River Thames. Mr Zaman indicated suicidal intent. He was detained by police under Section 136 Mental Health Act 1983 and taken to a place of safety at Homerton Hospital where he tried to abscond and was physically restrained. On the morning of Sunday 8th December 2024, Mansoor was admitted to Ruby Ward at the NCMH as an informal inpatient. At 14:33hrs Mansoor asked to be escorted outside to smoke, staff declined, he escaped through a fire exit. Staff followed him, persuaded him to return and he re-entered the ward at 15:23 hours. A duty doctor was called to assess Mansoor. The consultation was shortened as Mansoor became agitated. The Junior doctor considered that a S.5(2) Mental Health Act 1983 emergency authorisation was indicated which would allow both restraint and rapid tranquilisation of the patient but deferred completing the decision to seek telephone advice from the on-call specialist registrar. After the duty doctor assessment at 15:31, Mansoor assaulted a ward staff member. At 15:37hrs he walked towards the fire exit door and kicked it open and walked out. Staff did a ground and area search but could not locate him. At 16.46 on 8th December 2024, a person believed to be Mansoor was observed [redacted] At 18.27 on 8th December 2024, staff at Ruby ward called police on 101 to report Mansoor missing. On 29th December 2024. The body of the deceased was recovered between Westminster bridge and Lambeth bridge
5	**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 could 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. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 2nd April 2026 .** 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 Mr Zaman's family, the Care Quality Commission (CQC), the Nursing & Midwifery Council, the General Medical Council I have also sent it to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 6th February 2026 [SIGNED BY CORONER]** [redacted]