



**East London**

**NHS Foundation Trust  
Information Governance**

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21<sup>st</sup> January 2026

**Our reference: FOI DA6380**

We are responding to your request for information received 24<sup>th</sup> November 2025. This has been treated as a request under the Freedom of Information Act 2000. We are sorry for the delay in responding to your request. Please note [REDACTED]

We are now enclosing a response which is attached to the end of this letter. Please do not hesitate to contact us on the contact details above if you have any further queries.

Yours sincerely,

FOI Team

If you are dissatisfied with the Trust's response to your FOIA request then you should contact us and we will arrange for an internal review of this decision.

If you remain dissatisfied with the decision following our response to your complaint, you may write to the Information Commissioner for a decision under Section 50 of the Freedom of Information Act 2000. The Information Commissioner can be contacted at:

Information Commissioner's Office  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire  
SK9 5AF

Tel: 0303 123 1113  
Web: [www.ico.org.uk](http://www.ico.org.uk)

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We promise to work together creatively to: learn 'what matters' to everyone, achieve a better quality of life and continuously improve our services.  
**We care . We respect . We are inclusive**

**Chief Executive Officer:** Lorraine Sunduza  
**Chair:** Eileen Taylor

**Request:**

**Question 1:** I would like to know what lessons have been learnt from [REDACTED] death and [REDACTED] hospital over a four year period involving section 17 leave together with the proposals within the Niche report.

**Answer:** This was addressed in the Niche report and the Trust's corresponding action plan (which can be found within Appendix 1), under recommendation 7 with regards to "Effective use of leave of absence (Section 17 of the MHA).

- The ward matron conducted an audit of leave standards and documentation relating to cases throughout 2024. The results are largely positive with some areas where further improvement will be monitored. It is intended that this audit will be completed on a quarterly basis to provide assurance of ongoing improvement. The questions included in the audit were as follows –
  - Was the patient reviewed by the clinical team?
  - Community team involved?
  - Risk Assessment completed?
  - Dialog+ and Safety Plan completed?
  - Patient informed and knows what to do in a crisis?
  - Family informed where appropriate?
  - Clear plan for leave documented?
- There was a [REDACTED] Task and Finish group to address adherence to Trust and Pan London Absent Without Leave (AWOL) Policy/Guidance and strengthen inpatient leave planning. There has been a training program developed which has been taken to all ward away days from 30th April 2025. This will be done on a yearly basis.
- The Trust AWOL/Missing Persons Policy was ratified in January 2025. This includes a new Leave Monitoring Form and Pre-Leave Risk Assessment Checklist which is being used on all wards.
- Two reviews have taken place to identify learning from Serious Incidents. One was a thematic analysis of areas for improvement in completed Serious Incidents/Patient Safety Incident Investigations from 2020 to July 2024. This was presented at the Trustwide Learning Seminar on 30th October 2024. One key theme identified was the breakdown of communication involving service users, family and relatives. On 27th February 2025, the Trustwide Learning Seminar focussed on carer involvement in care planning and risk management.
- A review of incidents that involved inpatient deaths has been undertaken and key themes shared across the Trust. A Trustwide Learning Lessons Seminar is scheduled for 2026 which will include learning from [REDACTED] death and from other incidents involving the use of Section 17 leave.

**Question 2:** How have policies been changed and what precautions have been brought in to protect other vulnerable patients.

**Answer:** Changes to policies and practices have been included in the Trust's action plan evidence which was submitted to Niche and to the coroner during the inquest (which can also be found within Appendix 1). A number of operational policies were amended, including the AWOL policy as described above. The [REDACTED] operational policy, and the Crisis Assessment Team



operational policy were also reviewed to reflect changes in service configuration.

**Question 3: Also what additional learning or advice has or is being provided by the Trust to a number of NHS witnesses who gave evidence to the inquest.**

Answer: All staff are invited and encouraged to attend the Trustwide Learning Seminars which are also recorded and available on the Trust intranet as an additional learning resource.

Where there are recommendations linked to staff training and development this has been detailed in the Niche action plan evidence within Appendix 1.

The Trust has reviewed question 3 of your request for information under the Freedom of Information Act (FOI) 2000.

Section 40 for the FOI Act states:

*(2) This exemption covers the personal data of third parties (anyone other than the requester) where complying with the request would breach any of the principles in the UK GDPR.*

Some of the information you have requested has the potential for those individuals to be identified. The Trust is therefore unable to provide this information.

Nonetheless, we can confirm that Trust policy is that staff receive both clinical and managerial supervision. Whilst Section 40 of the Freedom of Information Act 2000 exempts the disclosure of personal data, training needs were reviewed for the individuals who gave evidence at the inquest. Those individuals also received support during supervision and were given the opportunity to reflect, learn from and discuss concerns arising from this tragic incident.



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