CTI Paper prepared for Baroness Lampard, Inquiry Chair, in relation to

ABSCONSION INCIDENT DATA

SUMMARY

1. This paper seeks to summarise the witness statements of EPUT, NELFT, The Priory Group ('Priory'), Cygnet Healthcare and St Andrew's Healthcare (collectively hereafter referred to as 'the Providers') in relation to absconsion incident data.

2. The Inquiry asked the Providers to provide various information in respect of absconsion incidents in Essex between 1 January 2000 and 31 December 2023 ('the relevant period'). In particular, the Providers were asked to populate the template provided by the Inquiry, with data relating to absconsion incidents.

3. The purpose of obtaining such information at this stage, was to enable the Inquiry to investigate what was happening within the Providers in relation to absconsion incidents during the relevant period, and to inform any further lines of investigation and disclosure that the Inquiry might wish to seek. Potential further lines of investigation arising from the material provided are set out at the end of this paper.

4. Not all of the Providers have responded in time, or indeed at all:
    a. EPUT has provided a witness statement and 23 exhibits
    b. Priory has provided a witness statement and 10 exhibits

c. NELFT, Cygnet Healthcare and St Andrew's Healthcare have not responded in time for their material to be considered within this paper.

5. The Inquiry recognises that there are too many limitations to the data so far provided by EPUT and Priory (not least because both are continuing to search for relevant data and have adopted slightly different definitions of 'absconsion'), to enable any reliable conclusions. However, where possible this paper has attempted to suggest further lines of investigation for the Inquiry to consider.

INTRODUCTION

6. As set out in the Inquiry's Terms of Reference, the Inquiry is investigating circumstances surrounding the deaths of mental health inpatients under the care of NHS Trusts in Essex between 1 January 2000 and 31 December 2023.

7. Through analysis of the information provided to the Inquiry to date, absconsion by inpatients from mental health facilities has emerged as a recurring issue.

8. In order to meet its Terms of Reference and understand the significance of this issue, the Inquiry requested information concerning absconsion incidents via Rule 9 requests for evidence (and follow up Rule 9 requests for evidence) to EPUT (and its predecessor organisations, NEPT and SEPT), NELFT, Priory, Cygnet Healthcare and St Andrew's Healthcare.

9. The Providers were asked to provide the following absconsion incident data for the relevant period:
    a. The number of people who absconded each year from each inpatient mental health facility operated by the Provider, and how many of these were repeat absconsions by the same individual.
    b. The number of absconsion incidents per facility per year that resulted in:
        i. A death;
        ii. A 'near miss', which the Inquiry defined within the Rule 9 as 'an incident, act or omission in care that had the potential to result in harm, but did not, primarily due to chance or interception';
        iii. Any other kind of serious incident, defined by the Inquiry within the Rule 9 as 'an incident, act or omission in care with significant consequences requiring lessons to be learned in line with the NHS Serious Incident Framework (or in

accordance with any previous frameworks of a similar nature), for example an unexpected death, injury, or abuse.'

c. The number of Root Cause Analyses or other investigations conducted for absconsions.
d. A summary of any action taken in response to Root Cause Analyses, or any other similar investigations that were conducted following an absconsion within the relevant period.
e. An explanation of how learning is disseminated within the Providers and amongst staff members including any relevant processes.
f. A summary of any changes made following any action taken in response to any investigations undertaken in response to absconsion incidents.
g. A summary of what information and/or training is available to staff regarding the identification, prevention and appropriate response to absconsion risks.

10. The Inquiry was therefore seeking to obtain essential data and information in relation to absconsion related incidents over the relevant period. The Inquiry was looking for an overview of any internal and external investigations that followed such incidents, and any actions arising from any such investigations, including how learning was disseminated, resulting changes that were implemented and what training was available to staff in relation to absconsion related incidents.

11. The Providers have responded in varying levels of detail to the Rule 9 requests for evidence sent by the Inquiry. This paper will replicate and summarise the key points within the Rule 9 witness statement responses as well as highlighting any omissions or limitations identified within those responses.

12. If there are errors within the information that has been provided by the Providers, including within witness statements, those errors will necessarily

be replicated within this paper and accompanying presentation. The fact that this information has been replicated or summarised below does not mean that the Inquiry accepts that it is accurate in all regards.

13. The purpose of this paper and accompanying presentation is not to test the evidence or analyse it in any detail. The time for challenging the evidence provided as part of these contextual hearings will be at a later stage.

14. At the outset, the Inquiry would like to make clear that there are evidently limitations and omissions within the absconsion incident data that has been provided by all Providers. As such, this data must be approached with caution at this stage. Before coming to any conclusions that are to be relied upon in the final report, the Inquiry will work with its Independent Assessors and Experts, including the Inquiry's Expert Health Statistician, Professor Donnelly, to identify any deficiencies within the data provided and ensure that it is as complete and therefore reliable as possible. The Inquiry will further work with its Independent Assessors and Experts to ensure that any final conclusions reached in respect of the data provided are reasonable and appropriately evidence-based.

15. This paper was completed by **27 March 2025**, to allow sufficient time for disclosure to Core Participants ahead of the April hearing. As such, any material that was received on or after this date has not formed part of this paper or accompanying presentation. However, all such material will be considered by the Inquiry, and will feed into investigations to fulfil the Terms of Reference.

16. The Inquiry has received numerous exhibits from the Providers that will not be disclosed at this time, as whilst they are largely of relevance to the Inquiry's investigations, the Inquiry does not consider the documents pertinent to the issues to be considered in the April Hearing and takes the view that it is not necessary or proportionate to disclose them at this stage.

EPUT

17. Rule 9(13) was sent to EPUT on 22 January 2025, with a deadline for response of 19 February 2025.

18. EPUT provided the witness statement of Alexandra Green dated 21 March 2025 in response to the Rule 9 request. This is a 17-page statement, with 23 accompanying exhibits.

EPUT – Definition of 'Abscond'

19. EPUT state that they internally define an absconsion as 'a patient who absents themselves from an inpatient unit'. EPUT further state that they internally define an incident as 'an event or circumstances which could have resulted, or did result in, unnecessary damage, loss or harm to a patient, resident, member of staff, visitor or member of the public under their care/on their premises.'

20. The Inquiry wrote to EPUT on 19 February 2025 and defined absconsion slightly differently, as 'any incident or occasion when a person has been absent from a ward/unit, either expectedly or unexpectedly, in circumstances where that absence could or should be considered worrying.'

21. EPUT therefore state that when providing the data to the Inquiry, attempted absconsions have not been included. However, EPUT confirm that they have included all incidents where a patient absconded from a unit, or did not return as planned from escorted or unescorted leave.

EPUT – Approach to Data Collection

22. EPUT state that absconsion incident data has been collected by them from a variety of sources which cover different date ranges across the relevant period:
    a. Archive boxes containing paper incident forms for SEPT and NEPT covering incidents between 2000 and 2009 (this information will be provided in June 2025 following completion of manual searches).
    b. SEPT's formerly used Risk Management System, Ulysses, covering incidents between September 2000 and March 2011 (this information will be provided in June 2025 following completion of manual searches).
    c. NEPT's formerly used Risk Management System, Respond, covering incidents between January 2002 and September 2015 (this information will be provided in June 2025 following completion of manual searches).
    d. NEPT's Datix system, covering incidents between June 2009 and April 2017.
    e. SEPT's Datix system, covering incidents between April 2010 and April 2017.
    f. EPUT's Datix system, covering incidents between April 2017 and 31 December 2023.

23. EPUT state that there is an overlap in the usage of some of these systems, as there was a phased rollout of Datix, meaning that some paper forms were still being produced at some locations after the initial introduction of Datix. Therefore, until EPUT have completed further reviews, it cannot be confirmed whether any incidents at NEPT since June 2009 and SEPT since April 2010 would have been recorded only on paper, Respond or Ulysses (without an incident also being raised on Datix).

24. In relation to EPUT's Datix system, they were able to extract the relevant data as the system specifically has a category for 'Abscond.'

25. In respect of NEPT and SEPT Datix data, 'Abscond' was only used as a category on SEPT's Datix form since 1 April 2011 and NEPT's Datix form since 1 September 2011. Therefore, EPUT state that they extracted all incidents from these databases between their implementation and the date that the 'Abscond' category was introduced and searched the data using specific search criteria to identify any absconsion incidents.

26. EPUT state that through this review, they identified that some abscond incidents have been categorised using other categories on Datix (for example, 'Death' or 'Self-Harm'). As such, EPUT will complete the same process by June 2025 for:
    a. EPUT Datix data from 2017-2023;
    b. SEPT Datix data from 2011-2017; and
    c. NEPT Datix data from 2011-2017.

27. EPUT state that each absconsion incident listed on the template is an attempt by a single individual, although some attempts will have occurred simultaneously (where multiple people were reported to have absconded in a singular incident).

28. EPUT has not yet been able to provide the data in relation to whether a person who absconded was a voluntary or involuntary patient, as a manual review of information is required. The Inquiry expects EPUT to undertake this review by June 2025.

29. Where Datix indicates that the degree of harm was 'death', EPUT have recorded this incident on the template provided by the Inquiry as having resulted in a death [Exhibit AG-001].

30. Where Datix indicates that the degree of harm was 'no harm,' EPUT have recorded this on the template provided by the Inquiry as a 'near miss,' as per the Inquiry's definition within the Rule 9 request.

31. Where Datix indicates that the incident was subject to a Serious Incident or Patient Safety Incident Investigation, EPUT have recorded this on the template provided by the Inquiry as a 'serious incident.'

EPUT Summary of Limitations

32. EPUT has summarised the limitations to the data that they have provided as follows:
    a. Manual review is necessary to confirm the number of absconsions that were by involuntary/voluntary patients (due to be completed June 2025).
    b. Manual review is necessary to confirm how many root cause analyses and other types of investigation were conducted in relation to absconsion incidents (due to be completed June 2025).
    c. Manual review is necessary to confirm what actions were taken in response to any absconsion incidents, including any investigations (due to be completed June 2025).
    d. Manual review is necessary to confirm any actions and changes that were brought about by the result of an absconsion incident, including a short explanation of what led to that action or change (due to be completed June 2025).

33. Further, the Inquiry is unclear whether the data provided covers absconsion incidents whereby some level of harm was suffered, short of death and not requiring a Serious Incident or Patient Safety Incident Investigation. The Inquiry will likely seek to address this with EPUT and request updated disclosure accordingly. This is dealt with in the final section of this paper regarding next steps.

EPUT – Staff Training on Absconsion Risks

34. In their witness statement, EPUT set out various aspects of staff training in relation to the management of absconsion risks. It appears to the Inquiry that the position within the witness statement refers to EPUT's current practices (as of March 2025). As such, the Inquiry will likely want to seek confirmation from EPUT as to the training practices that were in place across the relevant period, and any changes thereto.

35. EPUT state that absconsion risk is currently managed through a combination of training and continuous learning.

36. EPUT assert that mandatory Clinical Risk Training is delivered for non-qualified and qualified staff which provides an overview of potential risks associated with patients. The Inquiry requested a list and summary of such materials, but EPUT have also provided these training documents within [Exhibit AG-002-002c] and [AG-003]. EPUT state that within the training modules, absconsion is detailed as a risk.

37. EPUT state that the Inpatient Multi-Disciplinary Team will consider the level of individualised presenting risk in relation to a patient absconding. EPUT have provided [Exhibit AG-004 Engagement and Supportive Observation training] and [AG-005 Therapeutic Engagement and Supportive Observation Policy].

38. EPUT state that there are 4 levels of observations in place which prescribe the minimum frequency staff are to observe patients on the ward (level one/general observations through to level four/continuous observation within arm's length).

39. EPUT state that local inductions are completed in clinical areas and will be specific to the area in which the staff member works, and includes the

physical environment, such as air locks (ie double exit doors whereby only one door can be opened at a time, thus creating an 'air lock'). In addition, EPUT state that their Security training for secure services and acute inpatient care includes the physical and environmental security factors, such as air locks and the risk of tailgating (whereby patients follow members of staff through secure doors). EPUT have provided documentation in relation to security training ([Exhibit AG-006] and [AG-007]).

40. An overview of the training currently available at EPUT has been provided by EPUT within their absconsion data template [Exhibit AG-001]. EPUT have further provided information in relation to the Security Training provided by SEPT from 2015-2017 [Exhibit AG-017].

41. EPUT state that they will undertake further investigation of the records ahead of June 2025 to attempt to provide a clearer picture of available training in SEPT and NEPT, depending on the documentary evidence that has been retained and can be located. The Inquiry hopes that this disclosure will clarify what training policies were in place throughout the relevant period.

EPUT – Actions Taken in Response to Internal Investigations

42. The Inquiry asked EPUT to provide a summary of the actions taken in response to internal investigations commissioned following absconsion incidents. EPUT state that they need to undertake a manual review to locate investigation reports and associated action plans to enable analysis to be conducted. EPUT state that they will endeavour to provide this information in June 2025. The Inquiry hopes that this can be provided as soon as possible.

EPUT – Absconsion Management and Policies

43. EPUT state that EPUT and its predecessors had policies in place since the early 2000s and summarises the policies in place since the formation of EPUT on 1 April 2017 as follows:

    a. Prior to any period of leave from the ward, staff are required to undertake a risk assessment with the patient and will be informed by the patient's immediate presentation and other corroborative information such as from the clinical handover and safety huddles held during the shift. EPUT has provided [AG-020-CG45 Clinical Guideline for managing leave for informal patients and for patients detained under the Mental Health Act].

    b. In July 2017, EPUT published a 'Missing Person/Absent Without Official Leave Policy and Procedure.' These have been provided at [Exhibit AG-008] and [AG-009]. EPUT state that these initial versions were updated to reflect learning from events, incidents and changes to practice. In October 2018, EPUT state that the Procedure was updated to include guidance on the process to request a police welfare check [Exhibit AG-010]. They further state that the Missing Person Concern for Welfare Escalation Protocol was introduced to alert the police for a response. The escalation process was further updated in June 2022 [Exhibit AG-011] and [AG-012]. EPUT assert that a tool was collaboratively approved for use by EPUT and Essex Police and remains in place and in practice to present date [Exhibit AG-013 Missing Person SBARD Tool].

44. EPUT state that they are currently working with the Police and system partners to develop a 'Right Care, Right Person' Memorandum of Understanding for escalation when a person has gone missing. They state that the aim is to ensure that all parties have clear processes in place that integrate well with each other to allow for the fastest possible response with

minimal risk of miscommunication. The Inquiry is concerned that such is not in place already, and presumably has not been throughout the relevant period, and may wish to investigate this further.

45. It appears to the Inquiry that EPUT have not addressed the position in respect of absconsion management and policies over the entire relevant period, within their witness statement. The Inquiry is likely to seek further disclosure and information in respect of this.

EPUT – Learning Responses

46. EPUT state that they aim to ensure that the services they provide are in line with the service specifications set at a national level, and that a number of actions have been taken over the relevant period to maintain or improve these standards (EPUT state that they have provided these details in response to Rule 9(6a)).

47. Within their witness statement responding to Rule 9(13), EPUT provide an example of their response to an absconsion incident in October 2020, whereby they introduced an 'airlock' (one door cannot open until the previous door is completely closed and this is operated by staff in Reception with a video intercom out-of-hours) at the Linden Centre, Chelmsford.

48. EPUT state that they have governance structures and measures in place to disseminate learning, both in relation to general learning and the specific opportunities for learning which can take place following an incident, a reportable Serious Incident or Patient Safety Incident.

49. EPUT state that once an incident is registered on their Datix system, there is a requirement for the Datix Handler to review the incidents to determine if there are any new learning opportunities.

50. EPUT confirm that their central Trust-wide learning forum is the Learning and Oversight Subcommittee, whose role is to assure the Safety of Care Group that learning identified through different workstreams has been reviewed and implemented across EPUT.

51. EPUT further state that there are various methods to cascade learning across the Trust, including:
    a. Through '5 Key Messages', lunchtime learning virtual events and team newsletters.
    b. Via discussion with Senior Managers in Care Unit Quality and Safety Meetings.
    c. Via the "Safety First, Safety Always" Strategy and "Culture of Learning".
    d. Through the Lessons Team (established in 2022) who capture learning and encourage the embedding of learning in daily practices.
    e. The Learning Collaborative Partnership Group was created in August 2022. They meet monthly to discuss learning points, how they should be shared and who with. Examples of shared learning include a monthly newsletter and 5 key messages poster ([Exhibit AG-014] and [AG-015]).
    f. Safety Learning Alerts are shared with relevant managers via Datix and contain information of learning identified, actions which need to be taken, and confirmation that action has been taken is logged within Datix. EPUT state that an example of this reactive response approach is provided in [Exhibit AG-016 Safety Action Alert (Tailgating)].

52. EPUT state that in 2022, they undertook a review of absconsion incidents from inpatient services. The process involved an initial review of incidents reported on Datix to identify focus areas, followed by the Lessons Team conducting site visits for further exploration before concluding on actions to be implemented.

53. EPUT state that they conducted a follow up review in 2024 focussing on reported absconsion incidents from April 2022 to March 2024. This review identified that there had been an increase in the number of absconsion incidents at two sites (Cedar Ward, Rochford Hospital, and Finchingfield Ward, Linden Centre), leading to further investigation from the Lessons Team and operational manager. EPUT state that the review aimed to understand the contributory factors to the overall increase in incidents, and to develop actionable recommendations.

54. The Inquiry notes that EPUT therefore confirm that between 2022 and 2024 there was an overall increase in absconsion incidents, hence the need for a follow up review to attempt to understand and address this increase. This may be something that the Inquiry wishes to investigate further.

55. EPUT state that the Clinical Handover Guideline [**AG-018**] and Safety Huddles processes [**AG-019**] were strengthened to reduce the risk of absconsion along with other risks on the ward by ensuring these are covered and identified when there is a changeover of staff.

Priory

56. Rule 9(5) was sent to Priory on 28 January 2025 with a deadline of 25 February 2025.

57. Priory have provided a signed witness statement in response to the Rule 9 request, from Gary Stobbs, Managing Director for the East region of health care within Priory, dated 21 March 2025. This is a 10-page witness statement with 10 exhibits.

Priory – Sources of Data and Approach to Data Collection

58. Priory state that they have conducted searches of physical records, central and local drives, and electronic data sources to provide absconsion incident data.

59. Priory state that they merged with Partnerships in Care ('PiC') in 2016 and there are limited records available to review in respect of the PiC sites prior to that date, but enquiries remain ongoing in relation to paper-based archives. Moreover, they state that Oaktree Manor ceased operations and closed in September 2019.

60. Priory state that prior to 2012, both PiC and Priory operated a paper-based incident reporting system utilising 'IR1' forms, and that searches of these physical records are ongoing.

61. In addition to searching physical 'IR1' forms, Priory state that they have also searched the following additional sources with relevant key words:
    a. Local and shared drives at all Hospital sites and within centrally saved folders;
    b. Ex-employees' personal local drives; and

c. Searches have also been undertaken both at site and in central archiving locations for any historical paper records.

62. In respect of electronic data, Priory confirm that relevant data has been retrieved from three incident reporting systems:
    a. Datix
    b. E-compliance (used by Priory between 2012-2019) and
    c. IRIS (used by PiC sites between 2014 – August 2019).

Priory – Definition of Absconsion Incident

63. Priory state that they have had several internal discussions about how to define what is meant by an 'absconsion.' They state that their starting point is that absconding means either that:

    a. A patient has left not just the hospital ward or building but has **left the hospital grounds** without permission; or
    b. A patient has, during a period of escorted leave outside the hospital grounds, **left their escort** without permission.

    Priory state that they have not currently included patients who are late returning from authorised leave (but who then return unharmed). However, the Inquiry notes that paragraph 46 of the witness statement seems to suggest that instances where a patient returns late from leave is classed as an absconsion incident by Priory. The Inquiry will need to clarify this with Priory: have they included incidents where patients returned late from authorised leave, whether harmed or unharmed, within the total absconsion incident figure?

64. The Inquiry informed Priory via email on 18 February 2025 that they should approach the term absconsion as covering 'any incident or occasion when a person is absent from **a ward/unit**, either expectedly or unexpectedly, in

circumstances where that absence could or should be considered as worrying.' This was in response to a request for clarification from Priory. It is of some concern that they do not appear to have then gone on to apply the Inquiry's definition when providing the witness statement and data in relation to absconsion related incidents (by only including absences outside the hospital grounds).

65. Priory state that they have categorised an absconsion as 'serious' where the patient has absconded by their definition (ie left the hospital grounds without permission or left their escort without permission outside the hospital grounds) and has come to or caused serious harm (such as being admitted to general hospital for an injury or attacking a third party).

66. Priory state that they have not included an attempted absconsion (which they define as a situation where the patient did not leave the site and no harm was sustained) within their data.

67. Priory consider that a 'near miss' absconsion covers the situation where a patient returns voluntarily and there has been no harm, following:
    a. A patient leaving the hospital grounds without permission; or
    b. A patient leaving their escort without permission outside hospital grounds.

68. However, the Inquiry notes that there are potential inconsistencies within the witness statement as to how the Priory have defined a 'near miss':
    a. Paragraph 12 indicates that a 'near miss' absconsion incident covers all incidents where either 'near miss' or 'no harm' is reported on Datix.
    b. Paragraph 16 indicates that a 'near miss' absconsion incident only covers the situation where a patient has returned voluntarily, and there has been no harm to the patient, following unauthorised leave from the grounds or their escort.

69. It is therefore unclear to the Inquiry exactly how Priory have defined a 'near miss' absconsion incident for the purposes of providing their absconsion incident data, as the definitions within the witness statement are inconsistent. The Inquiry will need to address this with Priory.

70. Priory states that their definition of 'near miss' may need to be further assessed by the Inquiry, and that they are ready to provide further information and data sets if an alternative approach is requested. The Inquiry will seek to ensure consistency of the data obtained across the Providers, and as such may seek further disclosure from the Priory, or indeed other Providers, in that regard. The concluding section of this paper in relation to next steps highlights the issues that the Inquiry needs to address with the Providers in order to ensure consistent definitions across the Providers.

Priory – Current Response to Absconsion Incidents

71. Priory appears to have set out current practices within the witness statement in relation to their response to absconsion incidents. The Inquiry is likely to seek further information from Priory in relation to practices that were in place throughout the relevant period, and any changes over time.

72. Priory state that absconsion incidents are currently reported on Datix and are initially subject to a local investigation on site by the clinical and management team. They further state that the findings from this review are discussed as part of Ward Rounds with the Clinical Team (for lower risk incidents) or referred upwards via the 24-hour notification system (for higher risk incidents).

73. Priory state that there are immediate actions taken at site in response to each absconsion incident, to locate the patient (local searches and calls to relatives) and the incident is reported to both the Hospital Director and Managing Director (or senior executive on call) for further advice and support to be given. Priory state that they have a missing person's checklist [Exhibit GS01] to refer to at all sites which advises on which agencies are to

be contacted and these actions are then accordingly documented on this form. Priory also have a missing patient information sheet [Exhibit GS02] for completion which is provided to the Police.

74. Priory maintain that there are a significant number of absconding incidents where a substantive investigation is not required. They say that this is because incidents generate immediate actions and local patient-specific learning or alteration in clinical management of risks.

75. In all cases where the patient has left the hospital grounds or their escort without permission, Priory assert that a 24-hour report (including a section for 'further action required') is prepared. This report is written by the Hospital Director, Director of Clinical Services or Ward Manager (based on the standard template). Priory state that it is circulated by email around key internal stake holders, including the CEO and members of the Central Quality Team to ensure notification within 24 hours. The Priory state that the criteria for upwards reporting are set out in the Priory incident management and reporting policy [Exhibit GS03].

76. Priory state that following a 24-hour report, a further 72-hour fact finding report (providing more detailed information about the incident) may be prepared and a Team Incident Review report may be completed depending on the seriousness of the incident. Priory state that 72-hour reports are reviewed weekly during a call Chaired by the Director of Quality. Priory confirm that a decision is made at a regional level as to whether a Team Incident Review or substantive investigation is needed (containing recommendations for actions to be taken by the relevant site).

77. Priory state that where areas for improvement are identified from a Team Incident Review or substantive investigation, an action plan [Exhibit GS04] will be drafted by the site, including timescales, responsibilities and review dates.

Priory –Learning from Absconsion Incidents

78. Priory state that they use information from any incidents across their sites (including absconsions) to inform the overall safety and approach taken across the services provided.

79. Priory have provided the example of a patient committing suicide after absconding from one of their (non-Essex) sites. They state that they initiated a programme of increasing fence heights in all adult acute mental health services across the group (including Chelmsford) to 3.2m as part of the action and learning. They also state that they reactively put in place specific risk assessment for outside spaces across all of their acute mental health services and ensured wide dissemination across Essex services. The Inquiry notes that Priory have not provided the date of this incident or associated learning and may seek this information.

80. Priory state that they have a number of additional mechanisms in place to assist with the effective sharing of knowledge and lessons learned across the organisation. Examples of these which have been provided in the witness statement are:
    a. Patient Safety and Experience leads, a role created in 2022, are stated to have the role of ensuring lessons learned are collected centrally and shared;
    b. Increased access to Policies and Standard Operating Procedure documents through the use of Priory's intranet;
    c. 9 different channels and forums for communication to assist with the dissemination of learning across the organisation;
    d. A clinical governance framework in place across all sites to support two-way learning;
    e. The clinical governance framework sets out that all sites are also required to complete quality walk-rounds of their services to ensure observations are being carried out as required; and

f. All sites also have a weekly Hospital Director 'huddle' with the Managing Director each Friday afternoon where immediate lessons for learning are shared amongst the region.

Priory – Staff Training in Relation to Absconsion

81. The Inquiry notes that the witness statement sets out current training practices in relation to the management of absconsion. The Inquiry may wish to further investigate what training was in place (and actually undertaken) during the relevant period, once disclosure is complete in relation to absconsion related incidents.

82. Priory have set out a record of some of the training available to Priory staff for some of the relevant period in [Exhibit GS05]. In relation to current practice, the witness statement claims that:
    a. All nursing and HCA staff receive mandatory training in the identification, assessment and management of patients and their risk profiles which includes absconding risk;
    b. All staff receive supernumerary days on the wards before being allowed to be included in the staffing complement for each shift, which includes awareness of the physical environment of care, including areas where a risk of absconding may require specific management;
    c. All nursing staff are required to undergo observation and engagement training and a competency assessment before they are able to complete observations on a patient;
    d. All sites complete local security training as part of their site induction plan;
    e. As part of local induction, all staff are subject to local procedures and policies in relation to section 17 leave procedures [Exhibit GS06] and the management of absconsions [Exhibit GS07] including escalation, search policies and completion of relevant reports;

f. All agency staff are required to complete an 'agency' induction checklist [Exhibits GS08 – 09] which covers local security procedures, environmental awareness, observation competency, location of emergency equipment, garden and courtyard access arrangements and current risk of patients on the ward for the shift they are working.

Priory – Nature of the Services and Patient Cohort

83. Priory state that Suttons Manor is a low secure setting where many patients have been transferred from prison or been diverted to hospital from court. As such, perimeter fencing of not less than 4.2m is required to impede absconding. There is a strong emphasis on security (including the requirement for a staffed reception area with an air lock and all doors must be locked with staff holding authorised 'secure' keys).

84. Priory state that Chelmsford is not a secure hospital and specific security features such as perimeter fencing and air locks are not mandated in terms of building or unit design. Priory state that the emphasis and conditions are designed to support a therapeutic setting with less security features.

85. Priory state that the incidence of absconding is higher in Child and Adolescent Mental Health Services ('CAMHS') and adult acute wards as patients are in a position to leave the grounds unobserved to access the local community. They provide an example of a patient taking grounds leave, having been risk assessed for a smoking break, but who may decide on a particular occasion to leave the grounds. Priory state that there are no mandated national guidelines or requirements on the height of security fencing for acute wards, but they have installed 3.2m fencing around the courtyard/garden of the adult acute ward at Chelmsford in order to deter absconding. The lack of national guidelines or requirements is something that the Inquiry may wish to investigate further in conjunction with its Experts.

86. Priory state that Elm Park is a neuro-rehabilitation service and many patients have physical or mental health conditions which restrict their ability to leave the site of their own volition and as such the incidence of absconsion is low.

87. Priory has provided a list of policies and related documents with relevant dates [Exhibit GS10] and explains that these are updated on a 3-year cycle or more frequently if required by changes in practice or national guidance. The Inquiry will review this list of documents and will likely seek disclosure to further its investigations.

NELFT

88. Rule 9(5) was sent to NELFT on 28 January 2025, with a deadline of 25 February 2025.

Cygnet Healthcare

89. Rule 9(5) was sent to Cygnet Healthcare on 28 January 2025 with a deadline of 25 February 2025.

90. An extension was agreed of 28 March 2025, and therefore due to time constraints any material received by Cygnet Healthcare has not been considered in preparing this paper and accompanying presentation.

St Andrew's Healthcare

91. Rule 9(5) was sent to St Andrew's Healthcare on 28 January 2025 with a deadline of 25 February 2025.

92. An extension was agreed of 28 March 2025, and therefore due to time constraints any material received by St Andrew's Healthcare has not been considered in preparing this paper and accompanying presentation.

Next Steps

93. The investigation of absconsion incidents is a vital piece of work to enable the Inquiry to fulfil its Terms of Reference.

Next Steps – Ensuring Consistent Definitions

94. As has been set out within this paper, it appears to the Inquiry that as between EPUT, Priory and the Inquiry, inconsistent definitions of absconsion, 'near miss' and 'serious incident' have been applied.

95. Furthermore, it appears to the Inquiry that there is potentially an evidential gap within the data provided in respect of both EPUT and Priory, whereby absconsion incidents short of death and serious harm have not been adequately captured by the data provided, albeit they may have been included in the total number of absconsions.

96. For completeness, the Inquiry will need to investigate the following matters raised throughout this paper, in order to ensure parity across the data provided by the Providers:

    a. Definition of Absconsion
        i. The Inquiry separately contacted Priory and EPUT and defined an absconsion incident as 'any incident or occasion when a person is absent from a ward/unit, either expectedly or unexpectedly, in circumstances where that absence could or should be considered as worrying.'
        ii. For the purposes of providing their absconsion related data, EPUT have included any occasion where a patient absents themselves from an inpatient unit, or did not return as planned from escorted or unescorted leave. They have not included attempted absconsions.

iii. For the purposes of providing their absconsion related data, Priory have only included incidents where a patient has left the hospital grounds or their escort without permission outside hospital grounds. They have not included patients who are late and return unharmed from authorised leave.

b. 'Near Miss'
   i. Within the Rule 9 request the Inquiry defined a near miss as 'an incident, act or omission in care that had the potential to result in harm, but did not, primarily due to chance or interception.'
   ii. For the purposes of providing their absconsion related data, EPUT have included any occasion where Datix indicated that the degree of harm resulting from an absconsion incident was 'no harm.'
   iii. Priory's definition of 'near miss' remains unclear to the Inquiry. They appear to have included figures for absconsion incidents whereby a patient left the hospital grounds or their escort without permission and returned voluntarily having suffered no harm. It is unclear whether they have included all absconsion incidents whereby 'no harm' or 'near miss' is recorded on Datix.

c. Given the differing definitions of 'absconsion' and 'near miss' as between EPUT and Priory, it is possible that Priory are underreporting figures to the Inquiry as compared to EPUT, who have adopted broader definitions in line with the Inquiry's expectations and definitions. The Inquiry will need to address this with Priory.

d. 'Serious Incident'
   i. Within the Rule 9 request the Inquiry defined a 'serious incident' as 'an incident, act or omission in care with significant

consequences requiring lessons to be learned in line with the NHS Serious Incident Framework (or in accordance with any frameworks of a similar stature), for example an unexpected death, injury or abuse.

ii. For the purposes of providing their absconsion related data, EPUT have included any occasion where Datix indicates that the absconsion incident was subject to a Serious Incident or Patient Safety Incident Investigation. It is unclear whether or not incidents resulting in harm but not being subject to any such investigation have been included in the overall number of absconsion related incidents. It appears that they may have been included (because the total number of absconsions within the template provided is higher than the sum of the deaths plus 'near misses' plus 'serious incidents'). However, the Inquiry will need to address this with EPUT.

iii. For the purposes of providing their absconsion related data, Priory have included any occasion where a patient has left hospital grounds or their escort without permission, and has come to or caused serious harm (such as being admitted to general hospital for an injury or attacking a third party). While Priory's statement acknowledges that there are categories on Datix for 'minor' and 'low' harm, it is unclear whether these figures have been included in the overall number of absconsion related incidents. As per EPUT, it appears to the Inquiry that they may have been included (because the total number of absconsions within the template provided is higher than the sum of the deaths plus 'near misses' plus 'serious incidents'). However, the Inquiry will need to address this with Priory.

e. The Inquiry may wish to address this issue by asking the Providers to confirm (by way of adding a column to the template) the number of

absconsion incidents per facility per year that fall between 'near miss' and 'serious incident.'

Next Steps – Further Investigations (in line with the Terms of Reference and List of Issues)

97. The Inquiry is considering the data that has been provided and the further data that must be provided. It is taking advice as necessary about this, including from its Expert Health Statistician, Professor Donnelly. The Inquiry is developing lines of investigation consistent with its Terms of Reference and List of Issues. For example, they may include:

    a. To what extent was consideration given to the ward environment? Overall, were wards fit for purpose?

    b. How was risk assessed and managed and how was this balanced against other care philosophies and principles (such as least-restrictive practice and the need for care to be therapeutic and recovery-focused)?

    c. Can any conclusions be drawn as to differences between ward types (eg secure) and the number of absconsions in that regard?

    d. Can any conclusions be drawn as to the differences between absconsions in relation to voluntary and involuntary inpatients?

    e. How did patients abscond from inpatient wards? Were safety precautions and preventative measures sufficient? If not, what were the reasons for this?

f. What policies and procedures applied and how did these change over the relevant period, in relation to absconsion incidents and training in respect of absconsion management?

g. To what extent were policies and procedures adhered to? Where they were not adhered to, were there any reasons for this?

h. Where a patient absconded from a ward, how were decisions made to involve the police? When the police were involved what was their role?

i. Have the Providers complied with any data recording requirements that were in force during the relevant period, particularly in relation to absconsion incidents?

j. Were appropriate steps taken in response to absconsion incidents, including lessons learned?

k. Have the Providers consistently defined an absconsion incident, attempted absconsion and 'near miss' for the purposes of providing the Inquiry with absconsion incident data? Have the Providers consistently defined these matters for the purpose of recording absconsion incidents on Datix?

l. Was appropriate training given to staff at all levels in relation to the prevention of absconsion?

m. Which wards had the highest number of absconsion incidents in a given year and across the entire period? Can any further conclusions be drawn from this?

n. Which wards had the highest number of absconsion related deaths in a given year and across the relevant period? Can any further conclusions be drawn from this?

o. Which wards had the highest number of absconsion related 'near misses' in a given year and across the relevant period? Can any further conclusions be drawn from this?

p. Which wards had the highest number of absconsion related 'serious incidents' in a given year and across the relevant period? Can any further conclusions be drawn from this?

q. Did any wards see a large increase in absconsion incidents year on year? Can any further conclusions be drawn from this?

98. This list is by no means exhaustive and the Inquiry will not necessarily be able to obtain answers to all of these questions. Once the full requested disclosure has been received from all of the Providers, the Inquiry will seek to fill any evidential gaps or demand a reasonable explanation as to why that has not been possible. Given the importance of this data in helping the Inquiry to understand what was happening within the Providers in relation to absconsion related incidents over the relevant period, the Inquiry expects the Providers to be open and honest throughout this process, and highlight any omissions to the Inquiry rather than leave their discovery to chance.

99. Given their prevalence, the investigation of absconsion incidents is a key theme that the Inquiry will be focussing on. Obtaining this data is very much the first step in investigating absconsion related incidents across the Providers within the relevant period.

27 March 2025

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