Witness Name: Alexandra Green

Statement No.: 1

Dated: 21 March 2025

Rule 9 reference: EPUT Rule 9(13)

LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF Alexandra Green

I, Alexandra Green, will say as follows: -

Introduction

1 I, Alexandra Green, am the Chief Operating Officer ('COO') within Essex Partnership University NHS Foundation Trust ('EPUT') and I have held this position since December 2020. Since January 2024, I have also held the position of Deputy Chief Executive Officer.

2 I have been in employment with EPUT since April 2017. Prior to this, and from 2011 onwards, I was employed by one of the predecessor Trusts, South Essex University Partnership NHS Foundation Trust ('SEPT').

3 I have worked in the health and social care sector for more than 25 years. I am a registered occupational therapist and have held a variety of leadership roles in the NHS and Local Authority. Prior to being appointed as the COO at EPUT, I was the Director of Health and Care delivery for West Essex Community Health and Care Services at EPUT and Essex County Council.

4 I now report directly to the Chief Executive Officer ('CEO'), Paul Scott.

5 This statement is made on behalf of EPUT in response to the request by the Inquiry to EPUT dated 22 January 2025, under Rule 9 of the Inquiry Rules 2006, with reference **'EPUT Rule 9(13).'** EPUT has been asked to provide data related to absconsions that occurred both within EPUT's remit and also its predecessor organisations, North Essex Partnership University NHS Foundation Trust ('NEP') and South Essex University Partnership NHS Foundation Trust. The data itself has been provided in a separate spreadsheet, whilst this statement will provide further information around the collection of the data.

6 I would like to offer my sincere personal condolences to anyone who has lost loved ones while receiving care from mental health services in Essex. This statement aims to address questions from the Lampard Inquiry about safety at EPUT. No part of this statement is intended to diminish the impact that the tragic loss of life will have had on families, loved ones and the EPUT staff that cared for them.

7 I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief. The information contained on the Absconds Template has been entered reliably and accurately to the best of my knowledge and belief based on the information available.

8 As a corporate statement filed on behalf of EPUT, the statement also discusses EPUT's management of absconsion incidents and its policies and processes. I have been able to rely on discussions with colleagues, as well as documents, in order to set out this material. However, much of the information requested by the Inquiry relates to the period before the creation of EPUT on 1 April 2017 and has required searches of the historic databases relating to its predecessor organisations still held and accessible by EPUT (see paragraph 14 below for a list of those databases and the searches performed). This statement sets out a summary of the documentary information that is has been sourced via these sources, together with supporting exhibits. In addition, EPUT holds archive boxes containing paper incident forms for SEPT and NEP covering incidents between 2000 and 2009, which it has not been possible to search to date. EPUT will continue to work to locate further factual information requested by the Inquiry about absconsions and the responses to them in those earlier years, and to supply documents as requested.

9 The Rule 9(13) request asked EPUT to provide the information requested in four weeks. The work involved in responding to this Rule 9 has included extraction and examination of data and manual reviews to verify the information provided. EPUT has used best endeavours in the limited time available to provide as much detail as possible and will seek to provide any updates to this statement if further information comes to light.

Approach to Incident Data Collection

Abscond Definition

10 EPUT defines the term 'abscond' as a patient who absents themselves from an inpatient unit. An incident is defined 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 our care/on our premises'.

11 The Inquiry provided guidance on 19 February 2025 that it defines an abscond 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 as worrying.

12 To align with the definition provided by the Inquiry, attempted absconds have not been included within the data provided. EPUT has included all incidents where a patient absconded from a unit, or did not return as planned from escorted or unescorted leave.

13 On 14 March 2025, the Inquiry provided clarification that Learning Disability services would be within the scope of the Lampard Inquiry. In line with this new guidance, the data provided in the provided template **[AG-001-Absconsion Template for EPUT R9 (13)]** has been amended to include incidents that occurred in Learning Disability services.

Identification of Abscond Incidents

14 Incident data has been collected from a variety of sources which cover different date ranges across the relevant period. These sources include:

- EPUT's Datix (Risk Management) System covering incidents from April 2017 to present;
- NEP's Datix System covering incidents from June 2009 to April 2017;
- SEPT's Datix System covering incidents from April 2010 to April 2017;
- NEP's Respond Database (Risk Management System) covering incidents from January 2002 to September 2015 (this information will be provided on 16 June 2025 following completion of the manual searches required);
- SEPT's Ulysses (Risk Management System) covering incidents from September 2000 to March 2011 (this information will be provided in June 2025 following completion of the manual searches required);
- Archive boxes containing paper incident forms for SEPT and NEP covering incidents between 2000 and 2009 (this information will be provided in June 2025 following completion of the manual searches required).

15 EPUT has focused on the review of data from Datix for this submission to the Inquiry, with the remaining sources to be reviewed and completed by June 2025. The following information relates to the approach taken for Datix data.

16 There is an overlap in the usage of some of the systems outlined in paragraph 14 above. There was a phased rollout of Datix across the Trusts, meaning that some paper forms were still being produced at some locations after the initial introduction of Datix. Respond was used at NEP for managing the SI investigation for incidents while the incident would have been reported initially through paper forms and once introduced, Datix. Until further reviews are completed, it can't be confirmed that no

incidents at NEP since June 2009 and SEPT since April 2010 would not have been recorded only on paper, Respond or Ulysses (without an incident also being raised on Datix).

17 After identifying where the relevant information was held, it was necessary to extract the Incident data directly from EPUT's Datix system using the following criteria:

- Type: Incident Affecting Patient
- Category: Abscond

18 Incident data was extracted from the legacy Datix RichClient Databases to find Datix incidents NEP and SEPT, going back to 2009 and 2010 respectively, using the same search criteria.

19 It was identified that the "Abscond" subcategory had been in use on SEPT's Datix form since 1 April 2011 and on NEP's Datix form since 1 September 2011. EPUT extracted all incidents from these databases between their implementation date and the date that the "Abscond" sub-category was introduced.

20 Of the SEPT and NEP data, EPUT conducted an initial search on these incidents using the Incident Description, Action Taken and Lessons Learned fields to look for key words related to absconds. Following some tests and a review of the incidents being flagged, the key words selected were:

- "abscon" (to capture "abscond", "absconded", "absconsion", "absconding")
- "absen" (to capture "absent and "absence")
- "failed to return"
- "missing"
- "AWOL"
- "escape"
- "climb" (to captured "climb", "climbing" and "climbed")
- "tailgat" (to capture "tailgate", "tailgating" and "tailgated")
- "airlock"

- “air lock”
- “air-lock”

21 The keyword search resulted in 348 incidents from SEPT and 834 incidents from NEP. A manual review of these incident details was conducted to determine whether the incident was relevant to this Rule 9 Request.

22 In summary, the categorisation of the incident (for EPUT, NEP and SEPT) and the review of search terms (for SEPT between 2009-2011 and NEP between 2009-2011 has determined inclusion in the data provided to the Inquiry. By undertaking the above processes and through data quality checks, EPUT has identified that some abscond incidents have been categorised using other categories on Datix (for example, ‘Death’ or ‘Self-Harm’). As such, using the described keyword search principles, EPUT will complete the same process for EPUT 2017-2023, SEPT 2011-2017 and NEP 2011-2017 Datix incidents. This will be completed by June 2025.

23 Absconsion deaths that have been identified in EPUT’s response to Rule 9 (1) have been included in our response to this rule 9 request, ahead of the complete review of all incidents to be submitted to the inquiry in June 2025. Some of these deaths will then be outside of the years that Datix covers.

24 The Inquiry request specified that incidents should be separated by facility. This was achieved using the team base and description columns on Datix. Paper incident forms also identify the facility that an incident took place in. Where there has been uncertainty, a manual check of the patient’s records has been conducted to confirm the location. This was populated on the provided template as the number of people who absconded per year, per inpatient mental health facility **[AG-001-Absconsion Template for EPUT R9 (13)]**.

25 Incidents on Datix contain fields to indicate people who were involved in the incident (including staff members, witnesses, patients, etc.). Where EPUT have been able to identify the person that absconded, this information has been used to determine the repeated absconsion attempts. This has been populated by ward and year on the provided template **[AG-001-Absconsion Template for EPUT R9 (13)]**.

26 Where multiple people were reported to have absconded in a singular incident, the incident has been duplicated so that all repeat attempts can be identified. This means

that each absconsion incident listed on the template is an attempt by a single individual, although some attempts will have occurred simultaneously.

27 If it has not been possible to identify the person involved in the incident from the Datix form, the assumption has been made that it is a first attempt at absconsion. If the person has not been listed against the incident form, a manual check would need to be completed to determine which patients were on the ward at the date of the incident followed by a review of all patient records around that time. Even with this approach, it is possible that the person involved in the incident cannot be determined and there would be a new risk of assigning the wrong person to the incident.

28 The Absconsion Template provided by the Inquiry **[AG-001-Absconsion Template for EPUT R9 (13)]** included columns for absconsions where the person was a voluntary or involuntary patient. Since 2010, in accordance with guidance issued by the CQC, EPUT was required to notify the CQC of absences of leave of a person detained under the Mental Health Act. Since the formation of EPUT in April 2017, Datix has captured this information, however validation will be required to confirm accuracy and for a full set of data to be provided, a manual review of information would be required. All incidents prior to the formation of EPUT would also need to be cross referenced against patient records to determine whether the person was voluntary or involuntary at the time of the incident.

29 The Datix systems for EPUT and the predecessor Trusts contain columns indicating the degree of harm. Where the degree of harm indicated 'death', the incident has been reported on the provided template as having resulted in death **[AG-001-Absconsion Template for EPUT R9 (13)]**.

30 For incidents reported on Datix, the degree of harm field was used to determine if the incident was a 'near miss', referring to an incident, act or omission in care that had the potential to result in harm, but did not, primarily due to chance or interception. If the incident was confirmed to be an absconsion after a manual review, and the degree of harm was listed as "No Harm", the incident was taken to be a 'near miss' and reported as such on the provided template **[AG-001-Absconsion Template for EPUT R9(13)]**.

31 The Datix systems for EPUT and the predecessor Trusts contain columns indicating if an incident was subject to a Serious Incident or Patient Safety Incident Investigation. This column was used to identify incidents that could be considered as a Serious

Incident, the incident was reported on the provided template **[AG-001-Absconsion Template for EPUT R9 (13)]**.

Summary of Limitations

32 EPUT's approach for incident inclusion in the Absconsion Template has been outlined above. I provide a summary below of the details for the columns required within the Absconsion Template workbook **[AG-001-Absconsion Template for EPUT R9 (13)].** Please note this will be subject to change once the data has been completed in June 2025:

- **Year**: The year of the incident has been obtained from Datix; all years have been located and included.
- **Unit/hospital name**: The unit and hospital name has been obtained from Datix; all unit/hospital names have been located and included**.**
- **Ward name**: The unit and hospital name has been obtained from Datix. Where an abscond was logged to a community based team, manual reviews were completed to confirm if this was an inpatient abscond for inclusion in the dataset.
- **How many absconsions were there**: The number of absconsions per ward per year have been determined from the Datix data using a pivot table
- **How many of the absconsions were by involuntary patients:** This will require manual reviews to confirm (by June 2025)
- **How many of the absconsions were repeat absconsions by the same individual**: This has been populated using a pivot table of attempts per patient per unit, to identify repeat attempts
- **How many of the repeat absconsions involved involuntary patients:** This will require manual reviews to confirm (by June 2025)
- **How many of the absconsions resulted in death**: The number of absconsion deaths per ward per year have been determined from the Datix data using a pivot table and filter for degrees of harm: 'death'

- **How many of the absconsions resulted in an event that would be classed as a near miss**: The number of near misses has been populated from the Datix data using a pivot table and a filter for degrees of harm: 'no harm'

- **How many of the absconsions resulted in any other kind of serious incident**: This has been populated using a pivot table including incidents that were flagged for investigation by the Patient Safety Team

- **How many root cause analyses were conducted this year**: This will require manual reviews to confirm (by June 2025)

- **How many other investigations into absconsions were conducted this year:** This will require manual reviews to confirm (by June 2025)

- **List the other types of investigations conducted**: This will require manual reviews to confirm (by June 2025)

- **What actions, if any, were taken as a result of any RCA or other investigation conducted this year:** This will require manual reviews to confirm (by June 2025)

- **List actions and provide the date the action was taken**: This will require manual reviews to confirm (by June 2025)

- **What other actions/changes, if any, were taken in relation to absconsions this year:** This will require manual reviews to confirm (by June 2025)

- **List action/change provided, the date, and a short explanation of what led to that action/change:** This will require manual reviews to confirm (by June 2025)

EPUT response to incidents

Staff Training - EPUT

33 Absconsion risk is managed by EPUT through a combination of training and continuous learning. EPUT delivers mandatory Clinical Risk Training for non-qualified and qualified staff which provides an overview of potential risks associated with patients **[AG-002-002c-Clinical Risk training for qualified staff]**; **[AG-003-Clinical Risk training for non-qualified staff]**. Within the training modules, abscond is detailed as a risk, and the clinically-led factors used to reduce the risk is inclusive of Therapeutic Engagement and Supportive Observations. The Inpatient MDT will

consider the level of individualised presenting risk in relation to a patient absconding and will assess as to the patient's need as part of the therapeutic engagement and supportive observation levels **[AG-004-Engagement and Supportive Observation training]**; **[AG-005-Therapeutic Engagement and Supportive Observation Policy V4.2 (2023)]**.

34 EPUT has in place levels of observations which are used to outline the minimum frequency staff are to observe a patient on the ward. The level of observation prescribed is based on a number of risk factors and are unified as follows:

- Level one / general observations: For patients assessed as low risk and the minimum level for all patients. The frequency of observation is once every 60 minutes.

- Level two / intermittent observations: For patients who pose a potential but not immediate risk. The frequency of observation is a minimum of four times every 60 minutes.

- Level three / continuous within eyesight: For patients at immediate risk who could, at any time, make an attempt to harm themselves or others. A nominated staff member will be allocated to each patient managed on this level of observation and the patient must be kept within continuous eyesight.

- Level four / continuous within arm's length: For patients who pose the highest level of risk to themselves or others and can only be managed by close proximity of the staff member to the patient. A nominated staff member will be allocated to each patient managed on this level of observation.

35 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. In addition, EPUT's 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 **[AG-006-Security in Acute Emergency Care Inpatient training]; [AG-007-Secure Services training].**

36 An overview of the training within EPUT has been provided in the Absconsion Template for EPUT **[AG-001-Absconsion Template for EPUT R9 (13)]**. Evidence of the Security Training provided by SEPT from 2015 – 2017 has also been located and exhibited **[AG-017 Security Training 2015].** Further investigation of the records will

be undertaken ahead of June 2025 to attempt to provide a clearer picture of available training in SEPT and NEP, depending on the documentary evidence that has been retained / can be located.

Actions taken by EPUT in response to internal investigations

37 EPUT has been asked to provide a summary of the actions taken in response to internal investigations commissioned following an abscond incidents. This will require a manual review to locate the investigation reports and associated action plans to enable analysis to be conducted. There are some 3908 absconsions already identified from the Datix reviews so far shown in the Table exhibited. EPUT will endeavour to provide this information to the Inquiry in June 2025, but the scale of the task can be seen from the data and figures provided. However, in relation to actions by EPUT, please see the account below and specifically paragraphs 56 – 63 which detail recent learning.

Key changes to policies

38 In relation to absconds, to guide clinicians, EPUT and (to the best of my knowledge) its predecessors had policies in place since the early 2000s. As part of this response, I provide a summary of changes to policies since the formation of EPUT on 1 April 2017.

39 Prior to any period of leave from the ward, staff are required to undertake a comprehensive 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. In collaboration with the patient, a Leave Risk Assessment form is completed which documents that a risk assessment has been undertaken, includes contact numbers for crisis support, what the patient is wearing, time of departing and expected time of return. **[AG-020-CG45 Clinical Guideline for managing leave for informal patients and for patients detained under the MHA]**.

40 EPUT has in place a 'Missing Person / Absent Without Official Leave Policy and Procedure'; post-merger this was published in July 2017 **[AG-008-EPUT Missing Person Policy V1 (2017)]; [AG-009-EPUT Missing Person Procedure V1 (2017)].** The Procedure has undergone updates since this date in order to reflect learning from events and incidents and changes to practice. The changes have been related to

responses taken for missing patients, which can be used by inpatient and community services.

41 In October 2018, the Procedure was updated to include guidance on the process to request a police welfare check **[AG-010-EPUT Missing Person Procedure V2 (2018)].** The Missing Person Concern for Welfare escalation protocol was introduced to alert the police for a response; this guided staff through the steps to follow in such events which involved contact via telephone; the completion of an unannounced visit to the patient's address; communication with the patient's relatives/carers; and with their GP and/or A&E departments. If these steps did not result in contact with a patient where there were concerns for their welfare, contact was made with the police where details of the steps taken were shared, and additional information related to risk were provided.

42 The escalation process saw a further update in June 2022 **[AG-011-EPUT Missing Person Policy V2.1 (2022)]**; **[AG-012-EPUT Missing Person Procedure V2.1 (2022)]**. The document 'Reporting someone missing to the Police' was appended to the Procedure and was built upon a communication framework, SBARD, to be used in events where EPUT staff need to report someone missing to the police. SBARD includes prompts of details to share with the police, which includes 'Situation, Background, Assessment, Recommendation, Decision'. The Tool was collaboratively approved for use by EPUT and Essex Police and remains in place and in practice to present date **[AG-013-Missing Person SBARD Tool]**.

43 EPUT is currently working with the Police and system partners to develop a 'Right Care, Right Person' Memorandum of Understanding (MOU) for escalation when a person has gone missing. This will 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. Once this MOU has been signed off within the system, a training package will be rolled out to all frontline workers.

Learning responses

44 National standards for mental health services, including secure services and Psychiatric Intensive Care Units (PICU), are published to outline the specification and service standards. This includes the environment and security of the wards and/or units. As detailed in the EPUT's response to Rule 9(6a), the various mental health settings from which EPUT deliver services aim to be in line with the service

specifications and a number of works have been completed over the Relevant Period to maintain these standards or make improvements. Environmental adaptations are completed with changing national guidance, and within the remit of internal learning and the prevention of harm.

45 In relation to environmental adaptations, as a response to the death of JB on 23 October 2020, EPUT introduced an airlock to the Linden Centre, Chelmsford. With the new door system, one door cannot open until the previous door is completely closed; this is operated by staff in Reception with a video intercom in situ out-of-hours.

46 Again focussing on EPUT processes in this statement, EPUT has governance structures and measures in place in order to share learning. Opportunities for learning can occur following an event, an incident or a reportable Serious Incident or Patient Safety Incident.

47 Learning occurs locally informally and formally. Once an incident is registered within Datix, there is a requirement for the Datix Handler to review the incidents to determine if there are any new learning opportunities. The information within Datix is extracted into meetings and forums for wider understanding and discussion. This can include team meetings, Care Unit meetings and EPUT Committees.

48 When an incident occurred which met the requirement for reporting under the Serious Incident (SI) Framework, this triggered communication with the CQC and ICB and the commissioning of an SI investigation. Incidents of absconding may be included in this definition of reporting, in particular where they have occurred from secure services, and where a degree of harm has been inflicted. Following completion of the investigation, the learning from this is brought to the attention of the team involved in the patient's care, the Care Unit and the Learning Oversight Sub Committee (LOSC).

49 The EPUT's central Trust-wide learning forum is LOSC. Learning identified from Care Units is discussed at LOSC. The role of the Learning Oversight Sub-Committee (LOSC) is to assure the Safety of Care Group that learning identified through different work streams has been reviewed and implemented across EPUT. The sub-committee ensures that processes and controls are in place to embed learning into clinical practice. It is responsible for monitoring effective systems and processes that review and discuss learning from various sources, identify trends or themes for further action, manage clinical risk issues, and provide assurance on mitigating future risks.

Additionally, the sub-committee agrees on the evidence required to confirm that learning has been embedded into clinical practice.

50 Methods to cascade learning to individual teams and staff members who may not have been directly involved in the patient's care or investigation included 5 Key Messages, Lunchtime learning virtual events, and team newsletters. EPUT's Patient Safety Incident Management Team monitors completion of action plans, where necessary.

51 In addition, Care Unit Quality and Safety meetings also provide a service-led forum where learning is discussed with Senior Managers. The Care Units are responsible for ensuring messages and learning is cascaded to individual teams, which can occur in handover meetings, huddles and team meetings.

52 Under the "Safety First, Safety Always" Strategy, EPUT saw the introduction of the Culture of Learning in 2022 as part of the commitment to develop robust mechanisms to identify and share learning, and ensure change is embedded in practice and sustained. To encourage the culture of collaboration and the sharing of knowledge and learning, investment was made in EPUT's Lessons Team. The Team includes analysts, facilitators, a database manager and multimedia specialist working with clinical and corporate teams and subject matter experts to capture learning and encourage the embedding of this in daily practices.

53 The introduction of the Lessons Team saw an update to the governance and process of learning. In August 2022, the Learning Collaborative Partnership (LCP) Group facilitated its first meeting to fulfil its Terms of Reference. The LCP meets on a monthly basis with subject matter experts and senior managers who report monthly into LCP. Managers/Subject Matter Experts provide key learning points and themes from their services and during the meeting, LCP members review submissions of learning and determine how this learning should be shared and who it should be shared with. Examples of shared learning include a monthly newsletter and 5 key messages poster **[AG-014-5 Key Messages July 2023 edition]**; **[AG-015-Lessons Identified Newsletter October 2024 edition]**.

54 The current reporting structure for LCP includes a monthly report into the Learning Oversight Sub Committee (LOSC), and the onward reporting for LOSC continues into the Safety of Care Group as detailed above. The Lessons Team also report outcomes from LCP into Quality and Safety Meetings which take place monthly within the Care

Units. An overview of learning is provided from LCP by the Lessons Team into these forums for key themes of learning to be shared up, down and across the organisation.

55 Outside of the LCP meeting, the Lessons Team have other methods of cascade which are reactive to the learning identified. 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. By way of an example, in March 2022, the Lessons Team developed a Safety Alert directly related to learning from tailgating **[AG-016-Safety Action Alert (Tailgating)]**. This was for the attention of staff who work in acute and specialist mental health inpatient services to draw awareness to incidents of attempted absconding with patients having an increased opportunity of successfully leaving the unit when staff leave their ward to respond to rapid response emergencies on neighbouring wards. Details of the learning identified were actioned for discussion amongst teams to identify local mitigations, and to increase awareness and vigilance in circumstances of rapid response.

56 In 2022, a review of absconsion events from inpatient services was undertaken. Initially incidents reported on Datix were reviewed which identified focus areas. The Lessons Team conducted site visits for further exploration and concluded actions to be implemented. The actions which related to security measures included additional security training which was completed online and a face-to-face module was built and delivered at site. The training incorporated elements of security from the Trust's secure services, and learning from incidents as described above. The training module is available to acute inpatient emergency care staff and is completed yearly.

57 In addition, it was identified that a door at one of the units required replacement, and the doorway had been recognised as an area of increased incidents as it was an exit used by staff members to attend rapid response across the wards. The front doors at the unit had been converted to an air lock system, so the same was then completed at the back of the hospital site to reduce absconsion risk.

58 The learning was taken to the recognised learning meetings, and in addition, as a response to the learning, EPUT published a short, animated video which captured outcomes of the review of abscond events, as detailed above, intended for viewing by operational teams alongside written communications.

59 In 2024, the Lessons Team completed a follow up review of abscond incidents. Data from Datix included incidents reported April 2022 to March 2024. The number of

reported incidents in this time period had increased at two sites (Cedar Ward, Rochford Hospital, and Finchingfield Ward, Linden Centre) which prompted further review, led by the Lessons Team and operational managers. The review aimed to understand the contributory factors to the overall increase and the incidents and develop actionable recommendations.

60 The analysis identified several contributory factors, categorised into three main areas: person-related factors (such as cognitive issues, personal preferences, and mental state), environmental factors (such as size of outside space), external factors (including family responsibilities), and organisational factors (including no-smoking policies) Understanding these complex, interrelated factors was integral for the development of effective strategies to reduce the number of attempted absconsions whilst maintaining the positive reporting culture so EPUT have accurate access to incident information.

61 To address these challenges a set of recommendations were developed aimed at enhancing patient safety and reducing absconsion rates. Recommendations included conducting thorough risk assessments for each patient and increased monitoring of higher-risk individuals; the development of patient information leaflets to emphasise the importance of remaining on the ward for personal safety; fostering therapeutic relationships between staff and patients to build trust; and clear communication regarding the potential consequences of absconding. Furthermore, implementing contact cards with emergency numbers for patients on authorised leave could provide crucial support during distressing situations with easy access to services when needed. The learning actions are underway.

62 EPUT's Clinical Handover Guideline and Safety Huddles processes 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. The Clinical Handover Guideline initially developed in May 2018 and reviewed subsequently, provides guidance to ensure that there is a system of effective communication between shift changes, which is intended to transfer essential information and highlight any associated risks necessary for the delivery of safe holistic care of patients **[AG-018-CG20 Clinical Handover Clinical Guideline].** It sets out a framework to ensure that handovers:

- Establish the needs of each patient to support risk assessment and management:

- Promote patient safety through communication of needs and risks promoting clinical discussion;

- Provide continuing of care by sharing effective communication regarding individual patient needs, risks and care plan reflecting changes; To guide staff to complete necessary tasks during the shift preparing for handover at the end of their shift and planning the shift ahead;

- Allocate ward and shift tasks from one shift to the next, Include risks and planning ahead for the next shift i.e. staffing/rotas;

- Are supported during the shift by Safety Huddles to promote proactive responsiveness to changing needs of individuals and the ward environment.

63 Safety Huddles are used as a quick and effective way to share issues and concerns about patients and the ward environment. They support proactive responsiveness to changing needs and emerging risks supporting patient safety and management of escalating situations. Any staff can request a Safety Huddle, but the nurse leading the shift is responsible for chairing a safety huddle during the shift or delegating to an appropriate member of staff. **[AG-019-CG20 Appendix 4 – Ward Safety Huddle]**.

Statement of Truth

The content of this statement is true to the best of my knowledge and belief.

Signed: [I/S]

Dated 21 March 2025