Ms Lisa Milner
Assistant Coroner
West Sussex, Brighton & Hove
Record Office
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PO19 1DD

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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27 February 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Morgan Rose Betchley who died on 9 March 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2 January 2025 concerning the death of Morgan Rose Betchley on 9 March 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Morgan's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Morgan's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused Morgan's family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raises the concern that there is no policy or guidance to staff for the assessment of risk posed by fixtures and fittings to patients with acute mental health needs at Sussex Partnership NHS Foundation Trust (SPFT).

NHS England's Culture of Care Standards for inpatient mental health settings clearly set out the importance of relationships between staff and patients being built on openness and trust. Positive relationships between staff and the people they support are fundamental to a person-centred care environment, and we know that trusting therapeutic relationships are the strongest predictor of good clinical outcomes for people receiving mental health care.

NHS England's Culture of Care Programme includes focused work on moving away from risk stratification as predictor of risk and supporting organisations to use a personalised safety planning approach. We recognise the delicate balance of supporting people to stay safe from self-harm and suicide, whilst ensuring the least restrictive practices are used and people's human rights are protected. In addition to this, we are planning some future work in response to the upcoming Health Services Safety Investigations Body (HSSIB) investigation into creating conditions for learning

from deaths in mental health inpatient services that will further define what is meant by the therapeutic relationship and how to promote and harness this within services.

NHS England has also engaged with NHS Sussex Integrated Care Board (ICB), the responsible commissioner for SPFT's inpatient mental health services, regarding the concerns raised in your Report. We have been sighted on the Trust's Serious Incident Report and note that a number of actions have been identified as a result of the review of Morgan's care. These include raising awareness with staff of the importance of updating care plans and therapeutic observations, with care plan audits in place, and ensuring that care plans are updated promptly following any incidents. An action was also taken to develop a training package for urgent care pathway and inpatient teams to increase awareness of the needs and risks associated with care experienced individuals. The ICB has provided assurance to NHS England that they are seeking updates from the Trust on all actions identified in the report. We note that you have also addressed your Report to SPFT and will consider their response to the Coroner once we have been sighted on this.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Morgan, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

National Medical Director