Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sussex Partnership NHS Foundation Trust, Arundel Road, Worthing, West Sussex, BN13 3EP via email [redacted]** **2. [redacted] Chief Executive, NHS England, Quarry House, Quarry Hill, Leeds, LS2 7UE via email [redacted]**
1	**CORONER** I am **Lisa Milner,** Assistant Coroner, for the coroner area of West Sussex, Brighton and Hove.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 21 March 2023, I commenced an investigation into the death of Morgan Rose Betchley, formerly Sladovic, aged 19 years. The investigation was concluded at the end of the Inquest on 22nd November 2024. The conclusion given by the jury was a narrative conclusion namely: Morgan died as a result of her own actions. Historical evidence suggests that in all probability Morgan's intent had been to self-harm as a cry for help and that it was not her intention to end her life. Morgan was a young vulnerable adult who had suffered with her mental health for many years, including a history of self-harm and suicidal ideations. Following a significant decline in her mental health she was admitted and Sectioned (under Section 2 and Section 136) on multiple occasions to several medical facilities for her safety and to receive an enhanced level of care. The evidence shows repeated failures to follow policies and procedures by the staff at Meadowfield Hospital. Failures relating to admission process, understanding of existing diagnoses, risk management, record keeping, family involvement and discharge planning prevented Morgan from receiving access to services she needed at the time. We consider it probable that if policies and procedures had been followed Morgan would have benefitted from a level of care more closely aligned to her complex needs, including her diagnosis of Autism.

	In the days running up to Morgan's death, there was a failure to act professionally by some members of hospital staff. Following an earlier incident of assault, the deceased's attempts to apologise were not handled in a professional manner by senior staff members of Rowan Ward, leading to a fractured therapeutic relationship. Whilst nursing staff did not actively exclude Morgan from receiving care, the situation was made unnecessarily stressful for Morgan. The evidence of the court focused on the frequency of observations on the night of Morgan's death. However, whilst it's possible that more frequent observations may have helped to better understand her level of risk, we feel it more probable that better quality observations and interactions would have led to a great understanding of Morgan's state of mind.
4	**CIRCUMSTANCES OF THE DEATH** Morgan had been struggling with her mental health for some time, but there had been a marked deterioration at the end of January 2023 due to various factors. From January 2023 she had, on a number of occasions, self-harmed and made attempts to take her life in the community, whilst detained under Section 2 of the Mental Health Act 1983, and whilst a voluntary inpatient. During this time, Morgan was admitted and discharged from mental health settings, through the consultant led discharge process and via Morgan self-discharging. On the 27 February 2023 Morgan experienced a psychotic episode which resulted in hospital staff being injured. As a result of this episode, Morgan self-discharged herself. Whilst in the hospital grounds Morgan attempted to hang herself from a tree and on this occasion, she was detained by the Police under Section 136 Mental Health Act 1983. Morgan was detained in the Psychiatric Intensive Care Unit under Section 2 and after assessment the section was rescinded and she was then transferred to Rowan ward on the 3 March 2023, where she remained as a voluntary inpatient. It was assessed that Morgan should be discharged into the community under the care of the Crisis Team on the 6th March 2023. Whilst waiting for a discharge meeting with the Crisis Team on the 9th March, in the early hours of the morning, Morgan sadly [redacted] hung herself.

5	**CORONER'S CONCERNS** During the investigation, my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:- There is no policy or guidance to staff for the assessment of risk posed by fixtures and fittings supplied by the Trust (in this particular case it was the Sussex Partnership Foundation Trust). There is therefore the risk that fixtures and fittings supplied and/or not removed by the Trust from patients, who are suffering from acute mental health, are at risk of utilising these items to take their own life.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th February 2025 I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - • **The family of Morgan Rose Betchley (formerly Sladovic)** • **Sussex Partnership Foundation Trust** • **University Sussex Hospital NHS Foundation Trust** • **West Sussex County Council** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated 2nd January 2025**  **Lisa Milner** **Assistant Coroner, West Sussex, Brighton and Hove**