South London and Maudsley NHS Foundation Trust
Office of the Chief Executive
Maudsley Hospital
Denmark Hill
London, SE5 8AZ
[redacted]

Dear Mrs Patricia Harding, H.M. Senior Coroner for Kent and Medway

Re: Catherine Mary Morgan
Date of birth: 07.09.1986
Date of death: 04.09.2024

Thank you for your Regulation 28 Report dated 19 May 2026, setting out your concerns to be addressed by various organisations, including South London and Maudsley NHS Foundation Trust (the "Trust"), in relation to the sad death of Ms Catherine Mary Morgan.

The Trust continues to offer its sincerest condolences to the family and profoundly regrets that deficiencies were identified by the jury in their conclusion in respect of the care provided to Catherine by the Trust. The Trust is committed to ensuring that lessons are learned from this sad case.

The concerns in respect of the Trust set out in the Learned Coroner's report were summarised as follows:

1. Risk assessments in respect of leave were not being conducted in accordance with NICE Guidelines
2. The systems in place for recording and communicating leave for a voluntary patient were inadequate
3. The system for monitoring return from leave was inadequate
4. Ward staff appeared to take a different approach to leave and return depending upon the status of the patient as a detained or voluntary patient
5. A photograph of the patient was not included in the grab pack, unlike detained patients there was no checklist for voluntary patients as to the measures taken to locate the patient

The Trust notes that the Learned Coroner has recognised that the Trust had identified and put in train work that needs to be undertaken to address these issues. However, the Learned Coroner also noted that much of the work has not yet been implemented or is not yet complete and that until this is done you remain concerned. We take this opportunity to provide further assurance and explanation with regard to changes implemented and ongoing at the Trust which are relevant to the above concerns including learning which has been implemented directly as a result of the Patient Safety Incident Investigation carried out following Ms Morgan's death.

1. **Risk assessments in respect of leave were not being conducted in accordance with NICE Guidelines, specifically evidence was given at the inquest that although dynamic risk assessments were undertaken in advance of leave being authorised, risk assessments were not consistent with NICE Guidelines.**

The Trust acknowledges that at the time of Catherine's death the Trust's approach to risk assessment was not yet consistent with NICE guideline NG225 Self-harm: assessment, management and preventing recurrence (2022).

However, the Trust has now fully adopted NICE and NHSE guidance on individualised risk formulation and management planning. The Trust's move to a personalised approach to risk has been launched in four phases:

- Phase 1: Listening and engagement (April – June 2025)
- Phase 2: Co-production and testing (July – September 2025)

- Phase 3: Implementation (October 2025 – January 2026)
- Phase 4: Evaluation

To carry this out, the Trust established two groups to work in partnership with:

1. Personalised Approach to Risk of Suicide Steering group; and
2. Lived experience reference group.

The Steering group provides strategic direction, approves major decision, ensures alignment with organisation goals and shares messages across staff groups and directorates. It includes representatives from across the organisation as well as external stakeholders. The lived experience group is a group of service users and carers as advocates for lived experience representation and had oversight of the Trust's co-production work.

Phase 1: Listening and engagement

In Phase 1, the Trust explored staff and service user and carer experiences of risk assessment and safety conversations. The Trust reviewed best practice, learning from other organisations and existing work taking place in the organisation.

As part of this phase, the Trust revised its Clinical Risk Assessment and Management of Harm Policy, which came into force in December 2025, and which was previously provided as part of the Trust's evidence. The revised version updates previous Trust policy to reflect NICE guidance on self-harm: assessment, management and preventing recurrence (2022), statement from NHSE on risk assessment tools and NHSE Staying safe from suicide Guidance 2025. The policy provides staff with clear guidance on risk assessment, formulation, and the ongoing management of harm, emphasising the need for an individualised, patient-centred approach moving away from traditional classifications of "low", "medium" and "high" risk. It supports the development of a collaborative and proportionate risk management plan with the patient, aimed at reducing the likelihood of foreseeable harm. The policy further highlights the critical importance of safety planning as an integral extension of the risk management process, incorporating crisis and contingency planning for patients with a history of self-harm or suicidal ideation, to mitigate the risk of recurrence and prevent avoidable future harm.

Aligned with this the Trust's risk assessment tool in the Trust's electronic Patient Journey System ("ePJS") has been updated to include a caveat that the tool should not be used to predict the risk of suicide and a tick-box acknowledging that the user understands this. The Trust would like to make further changes to the risk assessment tool in ePJS to support the personalised approach to risk. However, there is a now a 'changes freeze' in relation to ePJS, as the Trust is in the process of moving to a new provider (further detail below).

Phase 2: Cultural change programme

The Trust has mandatory training for all clinicians on the management of Clinical Risk, which must be completed every 3 years. As part of Phase 2, this internal training was updated to include the revised Clinical Risk Assessment and Management of Harm Policy.

In addition, all clinicians at the Trust have been given access to an NHS England eLearning module on Staying Safe from Suicide (which takes half a day to complete), which incorporates further training and guidance on delivering care in accordance with the revised NHSE and NICE guidance. The e-Learning module is designed to support all mental health practitioners to provide consistent high-quality approaches to suicide risk assessment and management. The sessions provide evidence-based guidance on how to approach and support people to stay safe from suicide and feature case study based exercises that allow practitioners to develop their knowledge and apply the guidance in real-world scenarios. There is agreement for this eLearning module to be added to the Trust's mandatory training schedule, using a staggered approach (with nurses prioritised), which is in line with NHS England's National Suicide Prevention Strategy.

Furthermore, the Trust has also been one of a handful of Trusts who have been working with the National Confidential Inquiry into Suicide as part of the journey towards a personalised approach to risk. The Trust has found it very helpful to learn from the experiences of other mental health providers and sharing the Trust's own reflections.

Phase 3: Implementation

The Trust has recently completed a procurement in relation to a new Electronic Patient Record ("EPR") system and work is underway with the appointed provider to develop a new EPR system with a plan for this to be in place by 2028.

The Trust has identified this as a huge opportunity for re-designing through the new EPR procurement. The Trust has therefore been participating in the EPR re-design process informing the new procurement and has been exploring potential changes to how risk assessments and safety plans are documented on EPR. Further detail of these potential changes are detailed below. It is noted that the new system will have capacity to do reminders when actions have not been carried out to help ensure clinical tasks are carried out in a timely fashion.

Phase 4: Evaluation

The Trust continues to evaluate its transition towards a personalised approach to risk assessment and suicide prevention. In respect of the Inquest process, it was identified there is still some work to be done with respect to aligning all other policies with the transformed Clinical Risk Assessment and Management of Harm policy. In particular, there are aspects within the AWOL, Absent and Missing Persons policy which retain "old" low/medium/high classifications, i.e. the checklist used to guide decision making where a patient is identified as AWOL. This policy has now been marked as under review as was previously indicated in the Trust's evidence in this case. The review, which is further explained below, is an overarching review of three interlinked policies namely, the s17 Leave Policy, the Leave for Informal Patients Policy, and the AWOL, Absent and Missing Persons policy which aims to strengthen consistency and clarity across these interlinking areas of practice whilst aligning Trust practices fully with the new clinical risk management approach and ensuring legal compliance with relevant Mental Health legislation. The review is being undertaken by policy leads under the supervision of the Trust Director for Social Work and the Trust Mental Health Lead and is planned to be completed and approved in the Trust's Mental Health Law Committee by October 2026. The requirement for grab packs to have a photograph and the lack of a checklist for voluntary patients will be addressed as part of the policy review.

2. **The systems in place for recording and communicating leave for a voluntary patient were inadequate and decisions were largely communicated by word of mouth which led to differences of understanding what had been agreed, the basis on which it had been agreed and by whom it was agreed. Documentation in respect of leave was incomplete and did not comply with policy. The nurse in charge was not informed of the decision for leave or the circumstances in which leave was granted.**

The Trust acknowledges the Coroner's concerns in this respect and recognises the paramount importance of clear information sharing and shared understanding throughout ward teams to ensure the safe use of leave by formal and informal patients.

Since Ms Morgan's death, the Trust has made significant changes to the way in which discussion and plans from ward rounds, including in relation to patient leave, are noted within EPJS and how these are shared through EPJS template documents to assist with robust handover throughout the MDT and between shifts. There is a Ward Round template (Appendix A) which guides clinicians in noting the discussion and outcomes from ward round meetings. Of note, there is specifically a space under the "Safety" tab for clinicians to record agreement and discussions around leave, however it is also anticipated that discussion and planning of leave will feature prominently in ward round discussions and to this extent they should also be reflected within the recorded considerations around risk as well as plans and actions for the patient arising from the ward round review.

The Trust's Leave for Informal Patients policy having been disclosed in the course of this inquest, the Coroner will note that it is and remains to be Trust policy that relevant senior nursing staff are required at the beginning of every shift, in line with the Clinical Handover Policy, to ensure that they are fully informed of relevant information with regard to the patients under their care to include current legal status, mental state, potential risks, and leave status. Trust policy requires firstly, receipt of a verbal handover from the previous nurse in charge and allocated nurse and secondly review of "*the ePJS MDT Handover tool and recent clinical records*".

In the time which has passed since Ms Morgan's death, a substantial piece of work has been undertaken to create an MDT/DCCM handover tool within EPJS which pulls together, directly from the relevant parts of EPJS, information that is relevant to clinical handovers within the Trust (Appendix B). This directly pulls relevant information from the latest completed Ward Round template for the patient, as well as other recent clinical notes and prompts clinicians who are handing over patients to consider and record all relevant aspects of patient presentation, risk and legal status. As noted above, the Trust requirement is for this information to be verbally handed over between clinical colleagues and for the document itself to be read by the clinician receiving handover. The Trust will engage with the new provider to see if the above process of pulling information for the handover tool can be further refined with the launch of the new EPR.

Since the incident, the hourly observation checks (which were completed incorrectly for Catherine at 12pm on 4 September 2024) have also been made electronic as part of the Trust's work in respect of its new Enhanced Care policy. The introduction of the checks (now known as 'well-being checks') in an electronic form (Appendix C) will make it easier for them to be cross referenced with the Leave Log to assist with monitoring patients on leave. It will also make it easier to audit the checks to ensure they have been correctly completed by staff.

The Trust acknowledges that safe patient care not only requires a strong system to be in place for recording and sharing relevant clinical information within the MDT. Correct and relevant information must be inputted into these systems. In this case, it has been identified within the Trust's PSII that there was a failure to document discussion around the recommended timing of leave – in particular that a suggested time of 15 – 30 mins for negotiated unaccompanied leave for Catherine was discussed during the ward round on 3 September 2024, however, this was not included in the note of the meeting on ePJS. On the 5 March 2026 this matter, along with broader considerations regarding management of informal leave and failure to return from planned leave were addressed within a Patient Safety learning article which has been published centrally and has been disseminated by Directorate governance teams to all relevant staff. A copy of this has previously been shared with the Coroner. *As a point of clarity, it is not Trust policy (and it would also be contrary to the legal framework) to mandate time limits for informal leave given the legal right of informal patients to take time off the ward as they choose. It is accepted that for some individuals, safety planning in relation to time taken off the ward might encompass suggestions around the amount of time which would be and feel safe, and where this is the case it is the Trust's expectation made plain within the aforementioned Patient Safety learning article, this discussion should be documented.*

With respect to other specific aspects of the Coroner's noted concern,

- It has been discussed as a learning point from this case at the Trust's Patient Safety Committee meeting on the 11th June that ward policies around the taking of leave including informal leave and the documenting of the same must be followed (for example if a form is required to be signed by a Registered Mental Health Nurse (RMHN) it cannot be done by a different professional such as a Nursing Associate). The learning was also discussed in the directorate learning event on 15th June. Having said that, the Trust considers it may need to update its policy in respect of registered nursing associates being able to sign patients out for leave, in light of the fact that registered nursing associates can coordinate shifts and the shift coordinator is able to sign people out.
- The Ward Risk Assessment for Section 17/Informal Leave form that was in use when Ms Morgan was a patient on the ward was not included in any Trust policy but was produced by the ward by combining the Section 17 leave risk assessment checklist and the Daily Leave Log to produce a new form. Because of the reference to section 17 leave it was not felt that this was appropriate to both detained and informal patients and thus a new standardised Leave Log has been developed that is appropriate to both detained and informal patients (Appendix D). With respect to the Section 17 leave risk assessment checklist, it has been identified that this is not in accordance with NICE guidance 2022 which does not recommend the use of risk assessment tools to predict the risk of suicide or to decide which patients receive treatment or are discharged. It is recognised that it would be helpful to capture within the standardised Leave Log/Leave Form that the patient's time off the ward has been discussed with either the Nurse in Charge or the Patient's Allocated Nurse (Trust policy allows both) who has confirmed in line with policy that there is no reason not to permit time off the ward as per the patient's request.
- The Trust is currently investigating options for producing the Leave Form electronically potentially within the Trust's "Enhanced Care on E-Obs" system, which is an electronic platform integrated with ePJS to enable recording wellbeing checks. Enhanced Care on eObs is a secure digital system that helps hospital staff record wellbeing checks and engagement during periods of enhanced care. It

replaced paper forms with a more efficient digital system using iPads. As mentioned above, the Trust has recently procured a new EPR system and will be exploring with the new provider the possibility of producing the Leave form electronically, in a similar way to Enhanced Care on E-Obs, so that the form would be easier to access for the purpose of recording and monitoring leave.

3. **The system for monitoring return from leave was inadequate, reliance being placed on hourly checks. The nurse conducting the hourly check at 12.00 when Catherine was due to return was not aware that she was on unescorted leave and did not escalate the matter to the nurse in charge with the result that the ward only became aware that she had not returned when her mother arrived at 12.50. Consideration was not given to the appropriate amount of leeway to be given to the patient before escalating the fact of them not having returned, with patients being given 30 minutes or more;**

   It is also relevant to consider under this heading the Coroner's additional concern: "**Ward staff appeared to take a different approach to leave and return depending upon the status of the patient as a detained or voluntary patient**"

As noted above, the Trust has identified the procurement and re-design of its Electronic Patient Record system presents an opportunity to incorporate recording and monitoring of patient leave (for informal as well as formal patients) within the patient's electronic record, for example by making the Leave Form an electronic document and therefore easier to access and monitor, as opposed to being solely reliant on a paper log.

In the meantime, additional measures are in place on the ward to which Ms Morgan was admitted where they have now introduced a whiteboard in the main nursing office with leave and return times written on it. This means that it is now much easier for nursing staff to keep track of whether a patient has returned from leave at the expected time. The board is updated when a patient is signed out and then on their return. This aspect of learning from the incident was part of the presentation at the Patient Safety Committee so that other wards within the Trust can consider implementing the same system.

Reminders and reflection to staff about accurate completion of leave logs/hourly leave checks have also been emphasised in a directorate learning event. It is also noted that if Leave Form can be recorded electronically, as is hoped, then this will provide a much clearer audit trail, including names of users and time stamps, so it will be easier to monitor compliance and promote learning compared with the existing paper systems.

The Trust notes the Coroner's specific concern with respect to the "leeway" given to informal patient's when they do not return from leave as planned, and a difference in approach to leave and return from leave applied between informal and detained patients. Whilst it is already Trust policy that staff should promptly escalate to the nurse in charge in the event of an informal patient failing to return from leave as planned and agreed (in accordance with the Trust's Leave for Informal Patients Policy), it is the intention that the planned review of that policy, alongside the review of the AWOL and Absent and Missing Persons policy, will ensure that relevant measures and considerations from the AWOL policy will be incorporated and reinforced within the revised Leave for Informal Patients Policy, to reduce discrepancies between the two approaches.

The aforementioned Patient Safety article circulated to staff on 5 March 2026 reinforced the following:

- That it is the responsibility of the member of staff allocated to the hourly checks to check whether the patient has returned from leave at the expected time; and
- Staff must act promptly if a patient fails to return from leave, setting out 5 steps to be taken including escalation to the Nurse in Charge, contacting the patient to understand the delay, contacting family and friends where appropriate, considering a welfare check or contacting the police if there is an immediate risk; and completing a Datix incident report.

A Blue Light Bulletin to share learning from the patient safety incident was issued on 10 March 2026 and emphasises that a serious incident had occurred due to staff being unaware that an informal patient had not returned from leave as expected. The bulletin highlights "the value of promptly checking on patients who do not return from leave" and sets out the relevant checks. The Bulletin has been raised in Trust governance committees, discussed with team business meetings and been made available to all staff (clinical and non-clinical).

In addition, there was a Lewisham Quality Meeting held on 13 April 2026 chaired by [redacted], Deputy Head of Nursing and Quality with attendance by front line clinical staff, including Band 5 and 6 nurses who carry out nurse in charge role. Learning and discussion was held in relation to the nurse in charge role, including the key role they play in relation to leave, expectations of those in that role and in light of the clearly set parameters of the role set out within the Trust policies and procedures.

This reflective session emphasised the role of the nurse in charge as not only the most senior nurse on duty but the clinical leader, risk manager, coordinator and decision-maker responsible for keeping patients and staff safe while ensuring high-quality, lawful mental health care. It was stressed that the nurse in charge holds overall accountability for patient care on the shift and their role in relation to escalating emerging risks on the ward, including making real-time decisions about calling the police.

In addition, nurse in charge performance of these responsibilities is assessed through monthly supervision and annual appraisal processes. Ward managers and matrons undertake direct observation of practice on the wards. Any concerns will be raised with staff immediately. Supervision is a space for continued reflection and learning, consideration of feedback, discussion of cases and case-based scenarios to test and enhance individual's understanding of the expectations and requirements of role, mandatory training completion is reviewed during supervision and additional training and support needs can be considered.

4. **A photograph of the patient was not included in the grab pack. Unlike detained patients there was no checklist for voluntary patients as to the measures taken to locate the patient**

The issue of a checklist is addressed above. With respect to the requirement to include a grab pack, policy requirements with respect to this will be reviewed as part of the Mental Health Law Committee's aforementioned tripartite Policy Review.

The Trust acknowledges the Coroner's concern that a photograph of the patient was not included within the grab pack and that, unlike detained patients, there was no standardised checklist documenting the actions taken to locate an informal (voluntary) patient who failed to return. The Trust's *Leave for Informal Patients Policy* already sets out the actions that staff must take when an informal patient does not return from agreed leave, including risk assessment, attempts to contact the patient, liaison with family or carers where appropriate, and escalation to senior clinicians and the police where required. Nevertheless, it is accepted that a standardised checklist of actions would be beneficial. In relation to patient identification, whilst a photograph was not available in this case, the grab pack contains detailed identifying information, including physical description and distinguishing features, which could assist police in locating and identifying the individual.

As part of the Trust's policy review and learning arising from this incident, arrangements are being strengthened to ensure a more consistent and robust approach for informal patients. The revised policy will introduce a standardised checklist, aligned to the processes already in place for detained patients, to provide clear documentation and assurance that all reasonable steps have been taken to locate a patient who is absent and considered at risk.

The requirement in the Trust's AWOL policy for there to be a current photograph associated with a patient's grab pack derives from the Mental Health Code of Practice's guidance that detained patients should have a photograph included in their notes (27.22). The Trust acknowledges that its policy does not make clear that this guidance relates to detained patients rather than voluntary patients.

The review will also consider requirements relating to the availability and maintenance of patient photographs within grab packs, subject to appropriate consent, information governance, and legal requirements. These changes will support consistency of practice, improve record keeping, strengthen assurance regarding actions taken, and enhance the information available to partner agencies, including the police, during missing person investigations.

Conclusion

The Trust regrets that the work that it has undertaken to address the learning that has arisen from this sad case and through the inquest process has not yet been completed. Nevertheless, the Trust hopes that the

information provided in this response provides reassurance to the Coroner and the family that work is underway and there is a timeline for action.

The Trust acknowledges that the principal outstanding actions at this stage are (1) the tripartite policy reviews to bring the policies in respect of leave up to date with NICE guidance and (2) the discussions with the new provider to explore how the Trust's systems in respect of documenting, communicating and monitoring leave might be strengthened under the newly-procured EPR – both of which are actions that will inevitably take some time to complete and embed.

In the meantime, the Trust has taken action through various forums to reinforce to its staff its expectations around the recording, communicating and monitoring of leave for informal patients, and the key role played by nursing staff in this, as well as continuing to embed NICE guidance and the individualised approach to risk assessment and safety planning.

The Trust would once again like to offer its sincere apologies and condolences to Ms Morgan's family for the shortcomings that were identified on the part of the Trust.

Yours sincerely

Interim Chief Executive Officer