REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1. CORONER

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

2. DATE OF REPORT

19 May 2026

3. 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. THIS REPORT IS BEING SENT TO

1. South London & Maudsley NHS Foundation Trust

2. Metropolitan Police Service

3. College of Policing

You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th July 2026. I, the coroner, may extend the period if an appropriate application is made.

4. YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary

5. SUMMARY OF CORONER'S CONCERN

South London & Maudsley NHS Foundation Trust:

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

Metropolitan Police Service

1. An overly rigid approach to the Right Care Right Person policy and affinity protocol resulted in a delayed deployment

2. A call handler informed SLAM to call London Ambulance Service to do a welfare check at the home address of the patient in circumstances where the ambulance service will only attend an address if the resident is known to be there

College of Policing

1. An overly rigid approach to the Right Care Right Person policy and affinity protocol resulted in a delayed deployment

6. ACTION SHOULD BE TAKEN

In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

7. INVESTIGATION and INQUEST

On 10 September 2024 I commenced an investigation into the death of Catherine

Mary MORGAN, aged 37 Years.

The investigation concluded at the end of the inquest on 16th March 2026**.** The conclusion of the inquest was Catherine Morgan took her own life whilst suffering from anxiety and depression

1a Multiple Injuries
1b

1c

1d

II

8. CIRCUMSTANCES OF THE DEATH

[Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words]

Catherine Morgan was diagnosed with mixed anxiety and severe depressive disorder. In July 2024 she left her flat in Lewisham and went to stay with her parents in Wimbledon where she was seen by a GP, a therapist and a psychiatrist.

On 27th August 2024 Catherine travelled to Eastbourne with the intention of ending her life [redacted]. Her parents reported her missing to Metropolitan Police Service (MPS) and it was quickly established by MPS that Catherine was at an intermediate station when she answered a call made by the police. She was safely brought back home by police on that occasion.

Catherine was taken to St.George's Hospital by her parents and was admitted as a voluntary patient to Lewisham Hospital under South London and Maudsley NHS Foundation Trust (SLAM)

which was the service provider of her registered address (not the address where she was then living).

On 4th September 2024 Catherine left the ward at 10.30. This was her first period of unescorted leave. She had agreed to return to the ward by 12.00. It was only discovered that she had not returned when her mother attended to take her for lunch at 12.50.

Ward staff reported Catherine missing to MPS at 13.17. Applying the Right Care Right Person Policy and Affinity Protocol MPS declined to investigate because Catherine's registered home address had not been visited. At 13.28 Catherine's father rang MPS to report her missing, providing information in relation to the earlier suicide attempt and detailing that she would not return to the registered address. MPS again declined to investigate.

At 14.02 Catherine's father again contacted MPS to confirm that she was not at her flat. MPS passed the case to South West London BCU which covers Wimbledon. The CAD was returned to the despatch unit to reassign to South East London BCU covering Lewisham. South East London BCU received the CAD at 14.26, Thrive+ summary recording the risk as high. The morning Operations Inspector (400) was covering for the afternoon inspector who was on a training course and marked the CAD for her to deal with without reviewing it himself. He was unaware of a number of calls from despatch alerting him to the CAD as he was away from his desk. When the afternoon operations Inspector arrived she went straight into a meeting without reviewing the CAD. At 15.39 Catherine Morgan's father called MPS as there had been no response by the police. This was passed to the operations room. At 16.02 the 400 was informed of the phone call from Catherine's father and read the CAD, putting in train enquiries to establish the level of risk (some of which was already known to the police). The CAD was graded as high risk at approximately 17.00 and the Missing Persons Unit (MPU) started an investigation. They received information from a phone trace request approximately 60 minutes later that Catherine's phone was within the Dover area and informed H.M. Coastguard (HMCG).

MPS notified Kent Police and requested an area search. HMCG mobilised when they were informed Catherine's cell site showed her near Dover Castle. Information about financial transactions confirmed her to be in Dover and at 18.59 cell site data placed her at [redacted]. A HMCG search team arrived in the area a few minutes later. A Kent Police resource was despatched at 19.13. HMCG located Catherine Morgan at the cliff edge at 19.45 and engaged with her. Kent Police arrived on scene at 19.47. Catherine Morgan jumped to her death at 20.16

The jury found the following failures by MPS possibly contributed to the death:

1. The call handler and despatch team applied the Right Care Right Person policy and Affinity Protocol too rigidly by not registering previous suicide intention resulting in a delayed deployment;
2. The Metropolitan Police categorising Catherine as a high risk in an untimely manner;
3. Internal communication:
a) didn't utilise existing information held within all available CADs which resulted in delays to the investigation
b) No inspector cover during senior leadership team meeting policy
c) Lack of prioritisation policy

The jury also identified non-causative failures by SLAM ward staff:

1. Unescorted leave not signed out by registered mental health nurse;
2. Nurse in charge unaware Catherine had been given unescorted leave;

3. Ward staff unaware Catherine had not returned from leave at 12.00/12.30;
4 General observation sheet incorrectly recorded.

9. CORONER'S CONCERNS

During the course of the inquest I heard evidence 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:

[250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This statement must not propose what action should be taken, as coroners cannot make recommendations].

Re: South London & Maudsley NHS Foundation Trust:

It is recognised that the Trust has identified and put in train work that needs to be undertaken to address the issues that arose at the inquest. Much of the work has not yet been implemented or is not yet complete and until this is done the following remain as concerns:

1. 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;

2. The systems in place for safeguarding voluntary patients in respect of leave and recording the decisions was 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;

3. The system for monitoring 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;

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

Re: Metropolitan Police Service:

It is recognised that MPS has identified and put in train procedures to address the issues that arose at the inquest particularly in relation to the approach of MPS following a decision to transfer a CAD to the BCU MPU. The following remain as concerns:

1. An overly rigid approach to the Right Care Right Person policy and affinity protocol resulted

in a delayed deployment. Even where call handlers have real concerns that someone not returning to a mental health unit is a high risk missing person, the outcome of the toolkit not to deploy is the same if the individual's address has not been visited, even when told that they would not go there. The way in which the policy was applied removed any discretion by call handlers and despatchers to deploy whilst checks at the address were being conducted. Evidence was given at the inquest that the call handler in the second call to MPS attempted to convey her concerns that there should be immediate deployment to her supervisors in despatch and was advised the police would not deploy;

2. A call handler informed SLAM to call London Ambulance Service to do a welfare check at the home address of the patient in circumstances where the ambulance service will only attend an address if the resident is known to be there;

Re: College of Policing:

It was recognised by MPS at the inquest that there was an overly rigid approach to the Right Care Right Person policy and Affinity Protocol resulting from the robust application of the policy and protocol (see above). Some changes have been made within MPS within the parameters allowed given national guidance and standards, but evidence was given to the effect that training as to the application of the policy, protocol and toolkit could result in the professional judgement of call handlers/despatchers/supervisors being restricted resulting in delays to deployment

10. COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:
[please do not use individual’s names, but instead roles/titles]

1.Metropolitan Police Service
2.South London & Maudsley NHS Foundation Trust
3. College of Policing
4. Family of Catherine Morgan
5. South West London & St George's Mental Health NHS Trust
6. Kent Police

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026) Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

Signature [redacted]

Chief Coroner

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors.

It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's PFD Publication Policy (2026), any representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision.