Dear Ms Combes,

Re: Inquest touching the death of Chelsea Blue Louise Mooney - Sheffield Coroners Court 7 March 2022-15 March 2022

We write in response to your request for further information regarding various themes you are considering relating to the prevention of future deaths. May we take this opportunity to thank you for the time allowed to prepare this response.

We are extremely saddened by Chelsea's death and the circumstances surrounding her death. We appreciate the concern and upset which this has no doubt caused her family and we sincerely hope that the response below will assure you that work has and continues to be done to reduce risk and prevent future deaths.

We will deal with the themes raised as per your email dated 18 March 2022.

Introduction

1. Cygnet Hospital Sheffield offers CAMHS Tier 4 PICU, CAMHS acute and CAMHS low secure services over three wards. We provide individualised care for young people who are experiencing a mental health crisis, and whose needs mean they cannot be supported in community settings or they may require a longer stay in an inpatient setting. The services provide safe, therapeutic environments with a focus on helping the young person stabilise, so that hospital treatment is no longer required.

2. Griffin Ward is a 12 bed low secure service that positively supports young people who may need a longer stay in an inpatient setting within a low secure environment. It offers a care and treatment pathway for individuals who may have complex mental health issues and whose needs and risk are such they need to be supported in this environment.

3. The ward focuses on working with individuals to understand their mental health and their risks and support their recovery. This enables them to be successfully discharged to a less restrictive environment and to reduce the possibility of relapse.

4. Griffin wards focus on leadership is led by the ward manager [redacted] who has developed an open and transparent culture. This enables all the staff on the ward to create a learning environment, whereby incidents and other risk factors such as patient mix are under constant review. As a hospital we also have two staff members that are identified as freedom to speak up guardians. Their role is to provide a forum for any concerns or issues that staff have about any aspect of their job, or issues they may need support with outside of work.

5. Griffin ward works in a dynamic patient focused and nurse led way that fosters therapeutic relationships to develop strong relational security to ultimately developing care pathways for successful discharges. This is supported with a full

multi-disciplinary team to underpin the Low Secure Model of Care. The model of care is process driven that enables both young people and family/carers to see the three distinct stages.

- Admission and Pre Admission
- Formulation
- Discharge Pathway

6. Cygnet Hospital Sheffield has a Young Peoples Council that is led by the young person's representatives from each ward. They bring to the Council any areas that they want to discuss that can vary from clinical matters to environmental issues, and anything else that is important to them. The Young Peoples Council is attended by the senior management team so any issues that require operational support can be achieved. The Young Peoples Council now links into a wider CAMHS Young Peoples Council that is a joint council across all the CAMHS hospitals within Cygnet (Sheffield, [redacted] and Bury). This allows for shared learning and experience.

7. A co-produced approach to service delivery is at the heart of everything we do at Cygnet Hospital Sheffield. This is evident throughout the young person's care delivery, in their plans, CPAs and ability to chair their own meetings. Section 17 leave is individualised and discharge planning and relapse prevention are the focus rather than containment.

8. This is also evident throughout the various councils and peer reviews that we have. The peer reviews are always led by the young person. Griffin (and all wards) have engaged in the Royal College of Psychiatry reducing restrictive practice collaborative that specifically focuses on reducing unnecessary restrictions that can lead to increased risk incidents that Chelsea lead on.

9. Having the input from families/carers is also very important. Family forums have been introduced which enable us to get feedback and changes can be made for individuals and also for service development. Family/carer contact is routinely completed during the week (where appropriate) with the addition of a questionnaire once their young person has been discharged. This reflects on their experience of the service. Again this feedback can be used to refine the service and address any areas that can be done better.

10. Cygnet Hospital Sheffield is committed to least restrictive practice and positive risk taking. This is identified in the audits, training and the positive and safe group that is held monthly. Cygnet Hospital Sheffield also has three certified Safety Intervention (MAPA) trainers that work at the site full time. Their role is to lead by example to provide a positive role model to all staff members. They also train and assess all new inductees to ensure their competence. As part of their role they also assess service development following learning from incidents. As an example they have this week proposed an extra day in the Safety Intervention (MAPA) training that specifically targets restrictive interventions. This looks at the use of seclusion, removal of unsafe items and use of rapid tranquilisation.

Having three trainers on site also allows for dynamic incident management as they are able to attend incidents in real time. This allows a true experience of the types of incidents that are occurring and the learning from these incidents. This can then by incorporated into the training on site.

11. It was discussed within the Quality Network for Inpatient CAMHS (QNIC) review that Griffin ward embraces positive risk taking, with no blanket rules on the ward. Each individual is treated as such and is individually risk assessed. Griffin ward was one of the first LSUs in the country to not blanket ban mobile phones. Access is based on risk and under constant review.

12. Through ward forums such as community meetings the young people are encouraged to challenge mutual expectations, this is both for their peers and also the staff. This gives them a forum to discuss what they feel is appropriate and not appropriate on the wards. It provides another forum for learning and an opportunity to improve patient experience.

Communication

"I am conscious that communication may not be automatically seen as something which would prevent future deaths however I heard evidence from Dr Niekirk(sic) that this should have been re visited with Chelsea at a later date. I also heard evidence that the capacity assessment for that decision should be time and decision specific. What I have not been able to find in the records is exactly what Chelsea meant by not sharing information. From the notes that have been shown to the jury it may be that Chelsea believed she was not to have any contact with family and this appears to not be what she wanted. Not sharing any information must be discussed with the young person so that those assessing their ability to consent to this are clear that they understand the consequences of that decision. For example a decision not to share information with family about incidents like a disagreement with a peer or a breach of a rule would be less significant than information about ligatures.

The evidence which I heard also appeared to be based on the view that capacity to consent was the only issue here. That is not the case; Chelsea was not 18, her parents still had parental responsibility for her and whilst she is entitled to privacy this should be in the context of her competence to manage the clinical information she is charged with. This has historically been considered in the context of young girls being given contraception without parents being aware and of course the Covid-19 vaccination for young people over 15 revisited this issue but competence for a young person is distinct from capacity and I am not clear that those two things were considered independently and they were certainly not reviewed.

I am also not clear, from the evidence, about how this decision would be revisited with Chelsea. It would appear that staff were waiting for Chelsea to identify that she had changed her mind and wished to share information with

her family. Arguably as a young person, this decision may have slipped her mind or she may feel that she could not change her mind. Whilst it is not the responsibility of Cygnet staff to promote a relationship with Chelsea's family if that goes against her wishes, offering her the opportunity to revisit previous decisions is important.

In Chelsea's case I am also concerned that the lack of relationship and communication between the ward and Chelsea's family meant there were missed opportunities to fully understand Chelsea's clinical picture. If Chelsea was telling staff things that were not true this is a concern and ought to have been fed into her clinical profile. This could have been done in such a way that Chelsea did not feel as though she was disbelieved and in some instances could have been done without breaching Chelsea's confidence."

Cygnet's Response regarding Communication

13. At Cygnet we also strive to involve families/carers in a young person's care, however, sadly that is not always possible for a variety of reasons. Therapeutic input is offered to all of the young people in a variety of different forms, from the Health Care Support Workers who are with the young people throughout the day and night, to the Nurses and Clinicians who carry out assessments regarding a young person's care and treatment. In addition, all of our young people also have input from their Social Care team and any other outside organisations that is felt necessary and appropriate.

14. During Chelsea's admission she had therapeutic input from the MDT which included input from the Healthcare Support Workers, Nurses, the Consultant Psychiatrist, Support Workers and Psychologist with whom Chelsea has a particularly good relationship. So much so, it was decided that the Psychologist working with Chelsea would remain her point of contact even after he stopped working on Griffin ward. This was to ensure that the therapeutic relationship continued and to avoid Chelsea having to engage with a new Psychologist. Information from these interactions was documented and used to build a clinical profile which in turn fed back to the MDT. Chelsea made multiple disclosures about significant sexual, physical and emotional abuse which she stated were perpetrated by members of her family including her parents. It is not possible to validate all disclosures and it would be detrimental to the therapeutic relationship if a young person felt they would not be believed. However, in circumstances whereby information was disclosed which triggered a safeguarding referral and the involvement of Chelsea's external social care team, a referral was made and information shared, which in turn was investigated as deemed appropriate by the social care team and the police. The Social Care team have a responsibility under the Children Act to also report information that is shared with them. Details of these disclosures were documented in line with internal safeguarding policy and were documented within Chelsea's suite of safeguarding care plans. In these circumstances Cygnet did not breach Chelsea's confidence but were acting in her best

interests and passing on the disclosures to the most appropriate parties to deal with such matters. The outcome of those investigations were also shared with the MDT and there were open social care concerns at the time of Chelsea's death. Chelsea also made further contact with the police just prior to her death. As well as using the external agencies to investigate matters, the disclosures were discussions in therapeutic interactions with Chelsea in order to continue to build a clinical profile.

15. Within Chelsea's risk assessment (START-AV), her relationship with her caregivers (parents) was documented as a key vulnerability factor (risk). However, despite that, Cygnet continued to encourage involvement of Chelsea's family and family therapy sessions with her Mum were recommenced. The first session was arranged with the family therapist on the 22 March 2021. The aim of this was to work with her Mum on gaining and maintaining a healthy relationship.

16. In November 2021, Chelsea's capacity to make decisions regarding information sharing with her family was discussed and documented **(Appendix 1).** A full capacity assessment was completed by [redacted] **(Appendix 2)** and Chelsea was deemed to have capacity to make decisions regarding communication with her family. This assessment and outcome was in line with the principles of the Children Act and the Mental Capacity Act which applies to young people from the age of 16. If consent to share information was obtained, Cygnet would also have to assess whether it was appropriate to share the information if it was likely to increase risk to a young person and this would apply even if the Children Act was considered in circumstances whereby consent was not obtained.

17. If a young person of 16/17 year-old is capable of giving valid consent then it is not legally necessary to obtain consent from a person with parental responsibility for the young person, in addition to the consent of the young person. It is, however, good practice to involve the young person's family in the decision-making process, if the young person consents to their information being shared, unless the young person specifically wishes to exclude certain individuals from being informed.

Changes implemented following Chelsea's death

18. Specific communication care plans to support the young person's communication with families/friends/significant others (and any terms and conditions in place where there are identified risks associated with such communication) are now in place for every young person on admission. These care plans are held by social work and are regularly updated in ward rounds (every 2 weeks). This has been implemented post Chelsea's death as a lesson learnt and shared via our CAMHS network with the other CAMHS service line within Cygnet. The care plans also specifically set out if information isn't to be

shared. It is also documented as to what information is not to be shared and why and how the young person has come to that decision and it is made clear that they are free to revisit that decision at any time. This is then discussed with the young person every 2 weeks thereafter and the decisions made by the young person and the rationale for that decision are documented. If it is thought that the young person lacks capacity or competence regarding such decisions a Mental Capacity Act assessment would be carried out.

19. The GMC provides guidance on the type of information that patients may need to know before making a decision, and recommends that doctors should do their best to find out about a young person's individual needs and priorities when providing information about treatment options. It advises that discussions should focus on the young person's 'individual situation and risk to them' and sets out the importance of providing the information about the procedure and associated risks in a balanced way and checking that young person has understood the information given.

20. As a lesson learnt from this incident the above will now be specifically documented to make it clear that this has been considered. This will be recorded in the ward round summaries.

21. There is a weekly parent/carer forum across CAMHS services that is open to all parents or carers of young people **(Appendix 3).** The purpose of this is to create a safe, judgement-free space so that parents and carers can seek support, share experiences, give feedback and receive information. This forum directly feeds into the governance structure of the hospital in order to support continued service development. In addition, parents/carers are free to contact the teams at any time should they wish to seek support or information. This forum is open to all parents and carers regardless of their involvement with the young person's care.

Debriefing

"I was advised in the evidence from [redacted] (sic) that Chelsea had not wanted to engage in the de briefs about ligature incidents. This meant that there was no evidence about why Chelsea used ligatures or what her intention was when she did use them. This meant that a full risk picture could not be obtained. There was no evidence that this lack of engagement had been revisited or that the lack of engagement had increased her risk profile both of which ought to have been considered. What would the approach of Cygnet staff be in relation to revisiting debriefing or factoring a lack of engagement into risk assessment.

Likewise there was no evidence about how staff debrief. I am concerned that the reason for the delay in Chelsea's check was caused by another ligature incident. Inevitably this, followed immediately afterwards by a second ligature

incident (Chelsea) will impact on the wellbeing of staff and their ability to carry out their roles. What are the contingency plans for staff to enable them to access support and in the moment to ensure that other staff can cover whilst they take a break without impacting on patient safety?"

Debriefs during Chelsea's admission

22. All of the young people are offered the opportunity and encouraged to discuss and open up about incidents that have occurred. These opportunities to discuss matters are provided by all staff involved in a young person care and treatment. If a young person fails to engage with staff, in any aspect of their care, then this would ultimately increase risk and would be discussed in daily meetings and ward rounds with the MDT and would form part of the their management strategy in their care plan.

23. All incidents are reported using the Incident Management System (IMS). Part of this system asks if a 'debrief' has been completed post incident. Chelsea did not engage in these processes immediate post incident, however there is evidence within the daily notes and therapy sessions to confirm that Chelsea did discuss the incidents in detail.

24. Chelsea would talk about the incidents that she had and her risk of future incidents during psychology sessions as well as with those members of the nursing team/support workers (including ward manager) that she had built up a good therapeutic rapport with. These discussions then fed into her formulation of risk, behavioural support plan and care plans and they were used to help guide the staff in the best and more appropriate interventions. These documents were reviewed at regular intervals in line with best practice.

25. Chelsea was also a valued Young Person Lead for Griffin Ward for the Royal College of Psychiatry Reducing Restrictive Practice (RRP) which looked at many aspects but also looked at ways of reducing incidents on the ward and Chelsea's views and the other young person's views were always taken on board.

Changes implemented following Chelsea's death

26. Cygnet Health Care has since changed its policy and changed the term debrief to post incident review to more accurately reflect the process **(Appendix 4).** This links to the incident management policy. All Staff have been allocated training on 'post incident review e-learning' to have additional training around engaging the young person post incident reviews **(Appendix 5).**

27. Different approaches have now been agreed by the young people in the community meetings with regards the completion of post incident reviews. The

approaches are that the post incident review is completed informally and completed by a person who has not been involved in the incident or the young person can also identify a person whom they feel comfortable to have the post incident review with. The young people have stated that they find it difficult at times when post incident reviews are done formally. This has been communicated in the Team Meeting and Unit Management Meeting to all staff with regards to different approaches when carrying out post incident reviews.

Support for staff members

28. Certain staff members carry radios that are allocated to security, response (which does not include the staff member carrying out the observations), nurse in charge and any staff member on 1:1 or above. All staff members carry an alarm and every ward has a 'response' member of staff allocated that can attend to any incident in the hospital. This is again emphasised in training to avoid any future delays. This process allows the staff member who has identified the incident to step back if required and/or carry on with the checks without impacting on a young person's safety.

29. When incidents occur on the ward a 'hot' debriefs will occur as soon as is practical after the incident. During these debriefs, wellbeing and staff support are discussed. If a staff member feels they need a break or extra support then the nurse in charge can contact SNOS (Senior Nurse on Site) who can then arrange cover from around the hospital if needed. In addition to this there are processes in place for 'cold' debriefs which can either be facilitated by ward staff themselves e.g. by nurse in charge, or lead support, or by a member of staff external to the ward.

30. In addition to the hot and cold debriefs, there are also reflective practice sessions that take place weekly on the ward where amongst other things staff can discuss how they might feel about any incidents. If requests for further support are highlighted here then this is discussed with the individual and their line manager.

31. Cygnet recognise the significant impact that serious incidents and emergencies can have on staff and have therefore invested heavily in two unique forms of peer support, which are Trauma Risk Management (TRim) **(Appendix 6)** and sustaining resilience at work (StRaW) **(Appendix 7).** TRim focuses on the trauma which staff make experience from dealing with significant incidents and emergencies and StRaW helps staff in how to cope long term. Since April 2021 Cygnet have highlighted the need for staff to engage in this training and have encouraged staff to engage in order to increase its efficacy.

Both of these initiatives are taken from March on Stress and trained staff across the organisation provide peer support to those who need it.

Culture

32. The evidence from Chelsea's family is that prior to coming to Cygnet, Chelsea had not used ligatures or been engaged in head banging. Conversely the evidence from staff at the unit was that it was not unusual on the ward and fitted with the context of low secure accommodation. Whilst I make no criticism of the staff who have normalised this behaviour seeing it day in and day out, how is this culture challenged to make sure that young people are discouraged from these harmful behaviours in the context of trying to get them to a position where they can be discharged to safely manage in the community.

    I would like to understand, during the period of Chelsea's admission, broken down by month, how many incidents of ligatures there were on Griffin Ward. I would also like to know whether there were any patients who did not use ligatures during this period on Griffin Ward and if so how many. **(Response - Appendix 8).**

    I also heard evidence in the inquest that staff had said to family that they didn't worry about ligatures as the patients always knew they would be found. I also heard evidence from Clinical Lead [redacted] about the fact that any item placed around the neck would be recorded as a fixed ligature. This recording in the absence of the debrief above gives no context to the ligature that young people have tied. It appeared that all staff were surprised that Chelsea had died but there was no evidence that staff were particularly

    What do staff do to ensure that culture is challenged and that complacency doesn't set in. This is not intended as a criticism of the staff merely a challenge to the reality that they face each day and what is and is not acceptable when viewed from the outside".

Cygnet's Response regarding Culture

33. All incidents are reported using the Incident Management System (IMS). There is daily ward level and Senior Management oversight on the number, type and severity of incidents on each ward every day, collectively and for each young person. This is to ensure that the senior management team are aware of the risk that is present and also respond if there is a need to add further support mechanisms to any ward. This could be for example, to stop admissions, to add extra staff, to arrange an activity coordinator and so on. It also allows the senior management to be able to apply quality control measures daily and ensure all reporting to external agencies are completed in a timely manner. This process also allows the senior management team to be able to identify themes and trends.

34. The themes and trends of incidents are an integral part of the monthly 'Positive and Safe' meeting which is in effect a monthly incident review meeting. The aim of this meeting is to identify themes and trends to be able to help reduce incidents. This ensures that risk is reviewed collectively by the Hospital to challenge and interrogate the data.

35. From the analysis of the data (Appendix 8) there is a clear reduction in the number of ligature incidents and this pattern has continued over time and a steady decline in ligatures can be identified.

36. The organisation is also piloting a programme called clinical skills stations which looks to enhance the training of nurses with practical simulation and these will cover observations and engagement, ligature awareness and removal and responding to a physical deterioration of a patient.

37. There is a recognition amongst the staff team on Griffin ward that the young people on the ward will present with a variety of significant risk behaviours and have a range of complex mental health difficulties. Training is delivered on risk assessment, risk formulation and risk management to all staff that come to work in the hospital. In addition, Specific Trauma informed training is delivered to all clinical staff across the hospital.

38. Griffin ward has been peer reviewed by QNIC (Quality network for inpatient CAMHS) who set the national standards for best practice within CAMHS inpatient wards. The reviews look at all aspects of care including ward culture, staff training, and management of risk. Griffin was last reviewed by QNIC on 11th November 2021, this process ensures that the quality of care has regular external oversight to support continual quality improvement.

39. Griffin ward is working towards CAMHeleon accreditation (Safewards is an organisational approach to delivering inpatient mental health services. The aim of Safewards is to minimise the number of situations in which conflict arises between healthcare workers and the young person that lead to the use of coercive interventions restriction and/or containment).

40. NHS England are responsible for the commissioning and quality of the service they are commissioning. The management of risk and ward culture are central to their quality assurance.

41. The CQC inspected the site in September 2021 and rated the service as good in all areas. Specifically they highlighted that the leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. They identified culture as an area of 'outstanding practice' on the CAMHS wards, referencing that the hospital had created a positive and inclusive culture on the CAMHS wards. The hospital had excellent LGBT support for young people. The hospital was proud that their staff team was representative of their patient group and staff modelled an inclusive approach

and were creative in approaching individual needs. They were mindful of the young person's preferred names and pronouns in care records, community meetings and room placements, and hosted celebratory Pride events. The young people were encouraged to celebrate their talents and some had used this to personalise the wards and their bedrooms with murals and paintings, many of which contained rainbows and other positive and inclusive imagery.

42. In terms of culture we have an organisational Freedom To Speak Up Guardian and local ambassadors who champion staff speaking up.

Checks protocol

"What is the protocol for checks that are done and what is and is not acceptable to Cygnet?"

43. A revised safe and supportive observation policy was ratified in June 2021.

44. The corporate observation policy has been reviewed post the RCA report. All changes have been communicated to the staff.

45. The intermittent observation recording forms have been amended to include a statement to the effect that the forms must not be altered or adulterated in any way from how they appear on the electronic policy page (29.04.2021). In addition, the forms were 'locked' (29.04.2021) so that they cannot be altered in any way. The revised observation recording forms were disseminated across the company to all services, service managers and managers who then disseminated these to staff teams within services via site governance meetings, staff team meetings and individual supervision.

46. The observation recording forms and observation practice are monitored via audit using the recording forms and CCTV. The recording forms are audited weekly (every Monday) and the CCTV audit is completed monthly. Any concerns with practice are addressed in supervision/performance monitoring. Although disciplinary action has not been necessary, it would be considered, if necessary.

47. The level at which a young person is being observed and reported on is based on the latest individualised risk assessment and care plan, as agreed by the multi-disciplinary team (MDT) where the risks that are present are identified in detail. All staff have access to the care plans. This is reviewed on a shift by shift basis in accordance with clinical need and is considered by the nurse coordinating the respective shift. Each shift has a handover where the young person's risks and observation levels are discussed. The type of risk that young person presents is discussed so each staff member is familiar with what risks they are looking for, e.g. ligatures.

48. Since Chelsea's death we have also reviewed the number of beds available on Griffin. We have reduced the makeup of the beds on the ward from 15 to 11. We have then created a bespoke area for an additional bed which is staffed separately by support workers. This has reduced the total number of the young person's on the main ward from 15 to 11, which has then reduced the number of observations required.

49. We have also made it explicit that all the young people are on one of the following levels which is consistent with Cygnet Health Care's Safe and Supportive Observation Policy:

Supportive Observation Levels – Schedule		
Supervision Level	Frequency	Comment
General Low Level	60minutes	Depending the overall acuity of the patient These are population: e.g. - 1hourly in Rehab Units.
Intermittent High Level	15 minutes.At least four times in an hour. OR 30 minutes. At least twice in one hour N.B. Intermittent observations MUST NOT be prescribed in intervals less than 15minutes e.g. 10minutes or 5minutes, or in intervals greater than 30minutes e.g. 40minutes.	Time explicit in care plan and DRA, agreed risk assessment and review
Continuous	Eye sight	Proximity must be agreed by MDT and documented in the care plan/observation plan.
	Arm's Length	Within arms length to enable immediate intervention
	Multi- Professional.	Requires more than 1 staff. Proximity must be agreed by MDT and documented in the care plan/risk assessment.

50. Cygnet continuously monitors and updates the way that restrictive practice is challenged, including enhanced clinical observations. Cygnet is corporately committed to working with all individuals in a least restrictive manner. Cygnet has implemented clinical aids to ensure that a consistent framework is followed to ensure that the clinical rationale for restrictions are clearly stated and that an exit strategy exists that is clearly communicated to enable least restrictive practice. All individuals that are subjected to enhanced observations are reviewed on a daily basis with the full involvement of the multi-disciplinary team.

51. For all levels of observation, the person undertaking the task of safe and supportive observations should be able to report on the following areas when undertaking the role:

    a. General behaviour
    b. Movements
    c. Posture
    d. Speech
    e. Expression of ideas
    f. Appearance
    g. Eating / dietary intake
    h. Mood, attitude and orientation
    i. Response to medication
    j. Physical condition

"What impact does it have when someone has difficulties with particular members of staff or particular characteristics of staff?"

52. The staffing for each day is reviewed both on the ward and also with the senior management team every day. If there is an issue with staff mix then this will be addressed and staff may be moved around the hospital. If the young person has preferences this is accommodated as much as possible, however if an incident occurs, the risk to the young person will always override the young person's preference.

53. All young people can also make requests regarding staff that are completing their observations. If this can be safely facilitated, it would be care planned and actioned. During the staff members' induction, it is emphasised that in an emergency situation, risk overrides the preference of the young person.

54. Staff are all trained in Management of Actual and Potential Aggression (MAPA) regarding de-escalation techniques and if they don't work and there is a risk to a young person, staff may have to advise the young person that a hands on approach will be taken. Maintaining the young person's safety will take precedent over the young person's personal preferences about who deals with the situation.

"What is the position of minimum checks where it is out with policy and how is this communicated to staff and what level of sign off would Cygnet expect for that?"

55. The level of observations for each young person is a multi-disciplinary decision that would be based on the individual's risk needs. The decision would be care planned and included in the daily risk assessments. The observation levels are also documented in the running records. The young person is also part of these discussions and included in any decision making process

56. The decision regarding the level of observations would be handed over to the ward staff verbally and also written on the observation front sheet.

57. Ward staff will hand over key information about the young person to oncoming teams at shift changeovers, these handovers include information about the young person's risks and their current levels of observation. If the risk to a young person is high and there is a need for an increase in observations, this can be agreed by the Nurse in Charge if a decision cannot be made by the MDT, if the increase in observations is required at night for example. Observations levels can be increased but they cannot be reduced without involving the Psychiatrist and MDT.

58. Since Chelsea's death a review of all observation levels and care plans has been completed to ensure they explicitly comply with the correct terminology of the safe and supportive observation policy. Following the review of the safe and supportive observation policy, the unit fully complies with the policy and the MDT do not deviate from policy.

"What is the position where a check is delayed because of unforeseen events elsewhere such as what happened in Chelsea's case?"

59. All staff on induction receive training in how to undertake observations of young people in line with Cygnet's safe and supportive observation policy. The training explicitly instructs staff, that if they are engaged in observations, they must not respond to any other activities or incidents on the ward, as to do so may impact their ability to complete the observations they are responsible for.

60. Staff are also subject to a competency assessment when commencing supernumerary shifts as part of their induction, prior to being include in the core staffing within their allocated ward team.

61. Daily checks (Audits) are completed regarding the observations carried out to see if any are incorrect or late and this is addressed with the staff member. If a check is delayed and harm to the young person occurs as a result, this would be referred to safeguarding.

62. Following Chelsea's death and the circumstances that occurred, her case is now used in staff inductions as an example of a delay, in order to highlight the importance of following the safe and supportive observation policy to the letter and to avoid any delays.

63. Team radios are allocated to security, response (which does not include the staff member carrying out the observations), nurse in charge and any staff member supervising young persons on 1:1 or above. All staff members carry an alarm and every ward has a 'response' member of staff allocated that can

attend to any incident in the hospital and essentially take over. This is again emphasised in training to avoid any future delays.

64. Staff and young people are also encouraged to raise any concerns they may have. How to raise a concern is a standing agenda item in the young persons' community meetings.

Communication with the patient (please note that additional information is detailed above under the heading of 'Communication')

"I heard evidence that if Chelsea had wanted to discuss how she was feeling or particular disclosures she would be directed towards a therapeutic member of staff. This potentially seems to mean that if a young person is struggling but a therapeutic member of staff is not available they have no means of discussing how they are feeling. I would ask for clarity on this position and how staff visit and revisit conversations with patients.

In this section I also include the position that a number of staff, Hannah Sultan most notably, stated that Chelsea missed her mum and her siblings but that she could not encourage contact with them. This seemed to be a missed opportunity to understand from Chelsea the reasons why she was not having contact with family but expressing a view that she missed them. Whether there was a misunderstanding and Chelsea thought she wasn't allowed contact or whether she was choosing not to have contact in spite of missing her family are different and exploration of these would be important".

Cygnet's Response regarding communication with the patient

65. All staff that work on the ward are therapeutic staff and would offer therapeutic and empathic conversations. All of the staff are trained to deal with such situations and the young persons are encouraged to talk to staff. If a young person does open up to them, this is documented and escalated to other professionals, such as the psychologist/social worker/nursing team who would then in turn discuss such matters further with the young person.

Circumstances regarding Chelsea

66. Chelsea would talk about the disclosures she made and how she felt about them with both MDT and ward staff. At times Chelsea would choose to talk about how she was feeling to certain people that she had built up a good therapeutic rapport.

67. Chelsea would also have specific conversations around trauma focused therapy in her psychology sessions with the hospital social care team regarding her relationship with family members and also the ongoing social care investigations and police investigations.

68. Following assessment under the MCA, Chelsea was assumed to have capacity, to make a decision about contact with her family and the team on Griffin supported Chelsea in the decisions that she made. At times Chelsea had contact with her Mum and at times she did not. Chelsea was never discouraged from speaking with her family if she wished.

CPR

"The jury concluded that the level of delay was not justified from the point at which Chelsea was checked by [redacted] *at 18:32 and the emergency response. We heard evidence that someone would be and should be in control of the CPR response. What is clear is that the jury hold a view that things were not done as quickly as they ought to be when considering the steps of CPR and that this contributed to Chelsea's death. I heard about the staff having CPR training, I heard evidence about the policy and I heard evidence about the unannounced training events however what I have not heard is evidence about how these are assessed as effective? It would appear that all of these things were in place at the time of Chelsea's death and yet the response was not quick enough."*

Cygnet's response regarding CPR

69. All staff complete Life Support Training whether that be Basic Life Support or Intermediate Life Support training dependent on the staff member's role. The training is completed annually. At the end of each session each participant is assessed by the trainer before being signed off as competent.

70. In addition the Hospital has a schedule of resuscitation drills that are carried out monthly at an unannounced time and part of the drill includes staff response times. The resuscitation drills are completed by the Resuscitation Lead for Cygnet Hospital Sheffield and the local Quality Manager. The resuscitation drills are assessed and a compliance percentage is generated. The Staff members' names that respond are also logged. If there is an identified issue raised regarding a specific staff member or any practice then they are put on the next BLS or ILS course as a refresher. The resuscitation lead is also a BLS trainer which allows for quick turnaround of training and also allows for in depth discussion and analysis following the drills.

71. The resuscitation lead has also been nominated to complete the ILS train the trainer course which allows her to then teach the ILS course. This is currently completed by an external trainer.

72. Since Chelsea's death, the Hospital also provides nurse drop in sessions with the ILS lead. During these sessions staff are encouraged to ask questions and practical refresher training is also provided for example regarding, airways, defibrillator, oxygen etc. These sessions are designed to make the nursing team

feel more comfortable and to provide reassurance with the apparatus and emergency equipment and to increase confidence.

73. As per previous aspect. The organisation is piloting clinical skills stations, these will cover three aspects such as observation and engagement, ligature awareness and removal and responding to a deteriorating patient. This will be piloted on three sites and then will be rolled out across the organisation.

74. The Director of Nursing also chairs a quarterly Resuscitation Committee which looks at all aspects of resuscitation within the organisation and also identifies any learning from incidents.

Lessons Learnt

75. "I am keen to understand how Cygnet share lessons learned across the network of hospitals it holds."

Cygnet's response to Lessons Learnt

76. The Group Director of Nursing for Cygnet ([redacted]) sends out a Lessons Learnt bulletin with any updates of shared learning. This is accessible on the Cygnet Portal at any time.

77. Local lessons learnt are disseminated in site governance and staff team meetings. These are then escalated to Regional Governance. This is then shared by the Regional Operations Director to Board via corporate governance.

78. The RCA investigation and local/ Group learning points are shared to Directorate Leads and Quality Assurance Managers. This allows the report to be shared by Directorate Leads at Group Governance meetings. The local action plan will be monitored by the Quality Assurance Manager as well as within the site Governance meetings. Quality Assurance Managers will share the practices embedded within their region.

79. The Executive Management Board and the Quality Risk and Safety Committee receive reports on Serious Incidents Requiring Investigations from the Group Safety Committee and their learning points. The Group Safety Committee through the Lessons Learnt Group serves to disseminate notable points and escalate risks accordingly.

80. Following a Serious Incident Requiring Investigation, a lessons learnt event day is held which is used to focus on and share details regarding the incident, the experience, and the lessons learnt to Cygnet colleagues. This meeting takes place over Zoom with an open invite to all internal staff. Guest speakers are invited to talk about the local and wider learning points.

81. Cygnet are also linked into the Mental Health and Learning Disability Forum where NHS and independent hospitals share lessons learnt with the wider membership of the forum.

    There are also learning conferences held across Cygnet so that all sites can hear about key incidents and the learning associated with these.

    On a monthly basis Cygnet hold an internal CAMHS clinical network chaired by our medical and nursing leads, this looks at best practice and also identifies learning as a key part of this meeting.

    All of the CAMHS wards within Cygnet also meet monthly in the 'CAMHS network'. This is another forum where lessons learned are shared and suggestions are made regarding practice that may impact the entire service line.

Finally, we hope Cygnet have been able to convey how seriously we view the matters raised by Chelsea's death and our commitment to learning. If you do have any further queries or points of clarification, please do not hesitate to contact me.

Yours sincerely,

[redacted]
Group Director of Nursing
Cygnet Health Care

Cc- [redacted], Chief Executive Officer, Cygnet Health Care